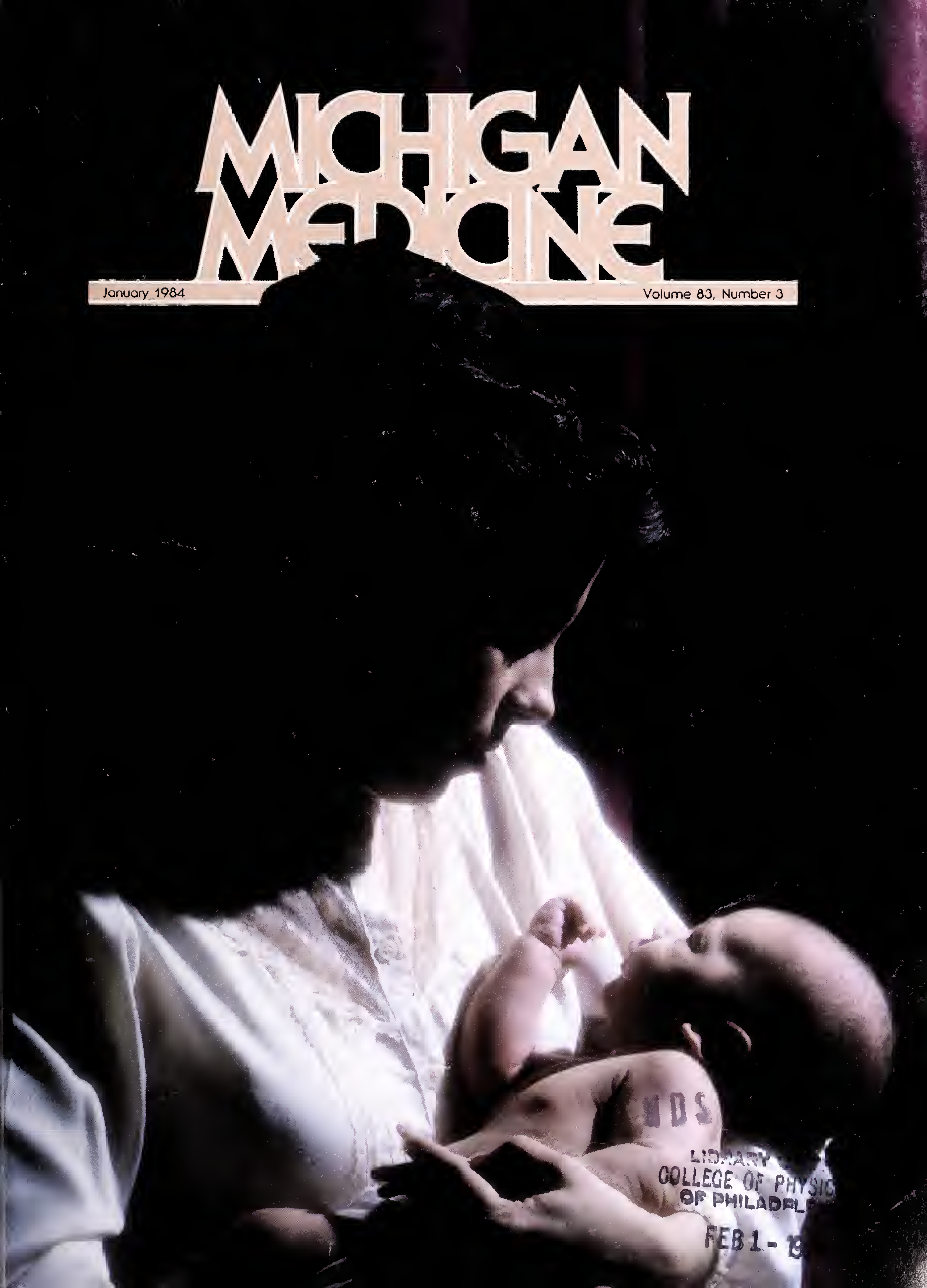
MICHIGAN MEDICINE

January 1984
Volume 83, Number 3



LIBRARY
COLLEGE OF PHYSIC
OF PHILADEL
FEB 1 - 19

Michigan Conference
on Maternal and
Perinatal Health

1984
Old Problems, New Solutions

March 28-29 Hyatt Regency Dearborn

For details: Michigan State Medical Society, P.O. Box 950, East Lansing, MI 48823 (517) 337-1351

January 1984, Vol. 83, No. 3

MICHIGAN MEDICINE

MICHIGAN MEDICINE

MSMS staff member Ginny Whitman and her month-old son Samuel Benjamin grace this month's cover, which spotlights the 1984 Michigan Conference on Maternal and Perinatal Health. Our special report, at the centerfold position, describes program and speakers. Photo by Kim Kauffman.

SPECIAL REPORT

21 Mother and child are the central subject of the Michigan Conference on Maternal and Perinatal Health. They are the theme of promotional materials on the cover of this magazine, and in the special report in this issue. The report appears in the center of this magazine, and is printed in burgundy ink on cream-colored stock, which are the colors of the conference. In the report you will find the complete program, with speakers and their subjects outlined. Registration forms will follow in the MSMS *Medigram* newsletter.

FEATURES

4 Photo feature on the 1983 MSMS Annual Scientific Meeting pictures MSMS members in classes, visiting exhibits and meeting colleagues

8 How Michigan physicians may cope with diagnostic related group (DRG) reimbursement systems; Samuel M. McMahon, MD

12 Practical suggestions for promoting patients' good health; David M. Cavataio

16 What happens when a major city hospital departicipates with the Blues: The Kalamazoo experience; Judith Marr

DEPARTMENTS

2 In my opinion; Harvey M. Andre, MD

3 Letters

14 Views; Gerald A. Drake, MD

26 Financial planning; Katharine S. Brown

29 Medical newsfronts

32 New members

34 News; Sheri W. Greenhoe

36 MSMS Auxiliary; Carol Batdorf

39 Meetings

40 Category I courses

42 Deaths

44 Classified ads

46 President's page; Donald K. Crandall, MD

Medicine's changing — so is *Michigan Medicine!* Starting with the page you are reading, typefaces, margins, headlines and layouts throughout the book have a new look for 1984. With the services of Wellman Press Art Director and Designer Martin Hudson, the magazine staff has worked to make the pages of the publication more inviting and easier to peruse. We hope you find them so! For those who like to know the details, the typeface is Friz Quadrata, in a variety of boldface and regular sizes to suit body copy and headline demands. Do you like the changes? Drop us a note and give us your reaction.

New KCMS members enjoy orientation session

By
Harvey M. Andre, MD

Our Hippocratic Oath requires that we freely give our knowledge of medicine to others, so that they too may have the proper knowledge and wisdom to care for the sick and injured. All physicians do freely share their medical knowledge. But, what about our knowledge of how our county and state medical societies are run, and the AMA? Do we freely pass on that knowledge, so that new young doctors know how the machinery of organized medicine works?

For more than 20 years the Kent County Medical Society has had an orientation meeting each autumn for the new doctors who have joined our society in the preceding year. One of our knowledgable senior doctors, Charles Farber, MD, has conducted his meeting for more than 10 years. We meet in a private dining room in one of our local clubs, and provide an excellent free dinner for our new colleagues. Doctor Farber discusses how our county society operates, one of our district directors describes state society operations, including how the House of Delegates and the board of directors functions. Another director then outlines how the AMA and its House of Delegates and executive committee operate. We also stress the values of MSMS and AMA membership including the many benefits that can be derived. In addition one or two MSMS administrative staff members are present to help fill in the details, and to answer some of the questions more precisely than some of the rest of us can. This autumn we again were honored to have Warren Tryloff, our administrative director, as our staff representative.

The questions our new members ask, plus the feedback we get after each meeting, are most gratifying. We are sure that after our new members attend our orientations they are knowledgable members of our local, state, and national organizations. The meetings let them know that not only is the Kent County Medical Society interested in them, but also the MSMS and the AMA. They also know where to go if they need assistance with any of their practice problems. Similar programs could be offered by every county medical society in the state. Kent County members will be very glad to help any get started. If they take Kent up on this offer, they will find their new members will take a more active interest in the county society, and in MSMS and the AMA. Such interest leads to a stronger organization, and today more than ever we need strong medical organizations.

Doctor Andre is a member of the MSMS Committee on Publications. He is an orthopedic surgeon from Grand Rapids.

Michigan State Medical Society
Warren F. Tryloff, director

Committee on Publications
Busharat Ahmad, MD, Marquette, chairman
Harvey Andre, MD, Grand Rapids
Vickers C. Hansen, MD, Manistee
Leland E. Holly II, MD
Donald N. Sweeny, MD
James H. Tisdel, MD, Port Huron

Editor
Judith Marr

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

MICHIGAN MEDICINE (ISSN 0026-2293) is the official journal of the Michigan State Medical Society, published under the direction of the Publications Committee. Published five times a month, 60 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $30.00; single copies, $1.50. Additional postage: Canada, $1 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to articles, news, exchanges, should be addressed to Judith Marr, advertising inquiries to Sheri W. Greenhoe and address changes to Peg Berry, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area code 517, 337-1351. ©1982 Michigan State Medical Society.

UCR v. indemnity

In the October, 1983 *Michigan Medicine*, MSMS published the summer report of the AMA Council on Medical Service. In that report the Council presented its arguments for an indemnity system of health insurance coverage in place of the present UCR payment system for physicians' services. The Council, which seeks to change AMA policy to support the former rather than the latter system, asked MSMS members' opinions on the issue. Following is one members' response. Others were published in the December issue of *Michigan Medicine*.

"I agree. I can tell the patient what his bill from me will be and whether he will have nothing to pay, or if he has to pay something. In addition, I can tell him how much. This way there will be no bad surprises.

"Most doctors, particularly new ones, put their fees high in order to get a new profile that is maximal. As a result, the inexperienced often are paid much more than the experienced.

"Let's go for it."

W.L. Howland, MD
Bay City

Accepting applications

The Graduate School of Public Health, San Diego State University, San Diego, California, is accepting applications from obstetricians, pediatricians, and other physicians interested in a career in the field of maternal and child Health. Applications are being accepted for *August 1984*. The training program is of nine months' duration. The Master of Public Health degree is awarded. Considerable effort is made by the faculty to assist each student in career planning.

There also is available a special 21-month training program for pediatricians in the field of handicapped children.

Inquiries should be addressed to:

Helen M. Wallace, MD
Division of Maternal
and Child Health
Graduate School of Public
Health
San Diego State University
San Diego, CA 92182.

Seat belt use

Congratulations on your excellent seat belt article.

You and Doctor Burton did a marvelous job in conveying the importance of seat belt use.

Willard S. Stawski, MD
Grand Rapids

ELECTIONS '84

In the upcoming 1984 elections Michigan voters will elect a U.S. Senator, 18 Congressmen and 110 State Representatives

MDPAC

MDPAC
MICHIGAN DOCTORS
POLITICAL ACTION
COMMITTEE

MDPAC *needs* your financial support in order to contribute to the campaigns of candidates responsive to the concerns of the medical profession. It is in the political arena that the major decisions affecting the medical profession are being made. Make a professional membership investment in

MDPAC

An MDPAC investment:

- Reflects physician commitment to political action and results
- Represents a large physician "precinct" motivated to influence the political and legislative processes that affect the practice of medicine
- Provides a coordinated means for medicine to support candidates who recognize and promote the aims of the medical profession

MDPAC Regular Membership ______ $ 50.00
MDPAC Sustaining Membership ______ $150.00
(All sustainers receive an MDPAC sustainer pin.)

MDPAC contributions should be written
on a personal check

MDPAC, P.O. Box 769, East Lansing, MI 48823

Michigan physicians filled the classrooms for many of the courses presented at the 1983 MSMS Annual Scientific Meeting. There were 55 half-day Category I courses presented Nov. 15-16-17 at the Hyatt Regency Dearborn.

1,200 MDs attend 1983 Annual Scientific Meeting

A focus of attention during the three-day event was the exhibit featuring the computer programs of the GTE/MINET system. MSMS Physician Service Group, Inc. sells arrangements for the system, which has been developed by the AMA. Above, MSMS board member Marguerite Shearer, MD, and her husband, Marshall Shearer, MD, watch a demonstration by Ellen Vinocur Potash, PSG staff.

As always during the Annual Scientific Meeting, the Basic Cardiac Life Support courses were popular. Registrations were filled long before the event. Above, physicians practice their technique.

Before and after classes and during breaks physicians toured the 70 educational and commercial exhibits arranged in the hall next to classrooms and registration.

Annual Scientific Meeting Chairman David R. Rovner, MD, East Lansing, right, monitored classes to evaluate the teaching, audiovisual aids and responses.

Photos by Mert Scholten, MSMS staff.

EMERGENCY
LIFE SUPPORT
STATION

Several of the classes featured round table discussions, an effective teaching method which fosters audience participation. At the table in the class on the physician's role in hearing and speech disorders are, from left, Carole Goff, MA, and Candace Gordon, MA, of the Speech and Language Pathology Department of William Beaumont Hospital, Royal Oak, who were speakers, and two of the participants.

Diabetes Course Director Dorothy Kahkonen, MD, Detroit, left, was one of the 55 physicians to organize and present courses. She confers, above, with speakers H. David Fachnie, MD, and Davida F. Kruger, MSN, both of the Henry Ford Hospital Division of Metabolic Diseases. Doctor Kahkonen is division head.

Many of the MSMS officers were students during the Dearborn meeting. From left are MSMS Secretary Robert M. Leitch, MD, Battle Creek; MSMS President-elect Louis R. Zako, MD, and long-active MSMS member Robert Rasmussen, MD, Grand Rapids.

Competence counts

Hurley Medical Center photo

In selecting a doctor, 74 percent of Americans consider competence, not cost.

Competent doctors remain the key to health. But competence isn't immunity to litigation.

Consider our competence – and our professional liability protection and strong-defense philosophy.

We defend you against non-meritorious claims. We won't settle a claim without your approval or merely to cut our defense cost.

PICOM
Physicians Insurance Company Of Michigan
4277 Okemos Rd., Box 1000
Okemos, Michigan 48864

(517) 349-6500
(313) 557-4845
1-800-292-1036

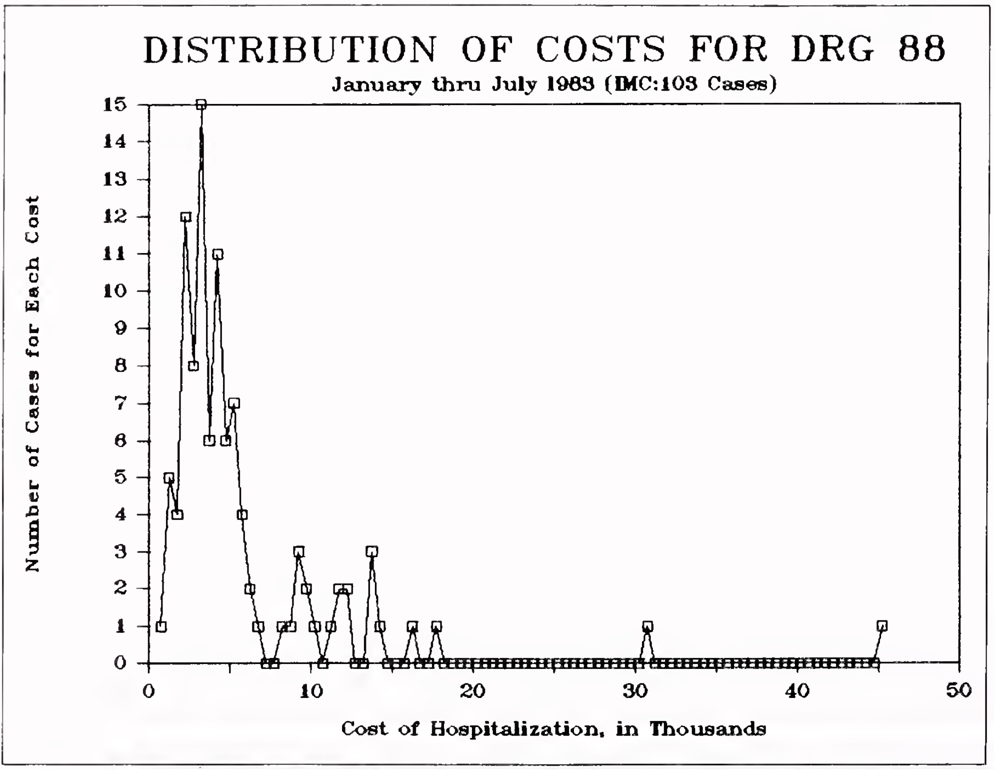
By Samuel M. McMahon, MD

Strategies for survival under the new DRGs

In October 1983, the Federal Government began a prospective system of reimbursement for hospitals caring for Medicare patients, based upon Diagnosis Related Groups (DRGs). This system, which was pioneered in New Jersey as a system to improve management for hospital administrators, divides all possible admitting diagnoses into 468 different categories, based upon the anatomical system involved and either the age of the patient or the degree of complication or comorbidity involved.

Although the DRG system was designed to enable comparisons to be made between hospitals to improve management practices, it has been adapted to a reimbursement scheme to decrease the chances that the medicare fund for hospital insurance will go broke by 1987 or 1988. Unless hospital care costs are decreased, a deficit of $300 billion is projected in 1995.

Under the DRG system, hospitals will be reimbursed a fixed, predictable amount for each DRG, regardless of the funds expended to provide care for the Medicare recipient. Hospitals which are more efficient could theoretically "win" by being reimbursed more than their costs. Less efficient hospitals will "lose" by being reimbursed less than the actual costs of providing care.



Physicians' fees are not currently covered by this program, although they will probably be covered by the same program within one to two years. Costs of capital and direct costs of medical education will continue to be reimbursed on the basis of the actual expenditures incurred.

The final weights to be applied for each DRG were published in the Federal Register on September 1983, providing hospitals with their first opportunity to study the details of this program and to compare their past expenditures with future reimbursement levels.

Distributions

It is generally agreed that DRGs will decrease the federal expenditures for health care costs. Health care costs in the US have grown enormously from $51.3 billion in 1967 to $362 billion in 1983. Medicare costs have increased 2.5 times as much as overall health care costs. Federal spending for Medicare now represents about 7 percent of the total budget, or about $57.3 billion.

As you know, there is a wide variation in the costs of providing care for patients with any single diagnosis or group of diagnoses. The variation in costs is real and depends upon how ill the patient is and how many other problems are present. The variation in costs also depends upon how skillful and efficient we are as physicians and how skillfully hospitals are managed. The government

Continued on page 10

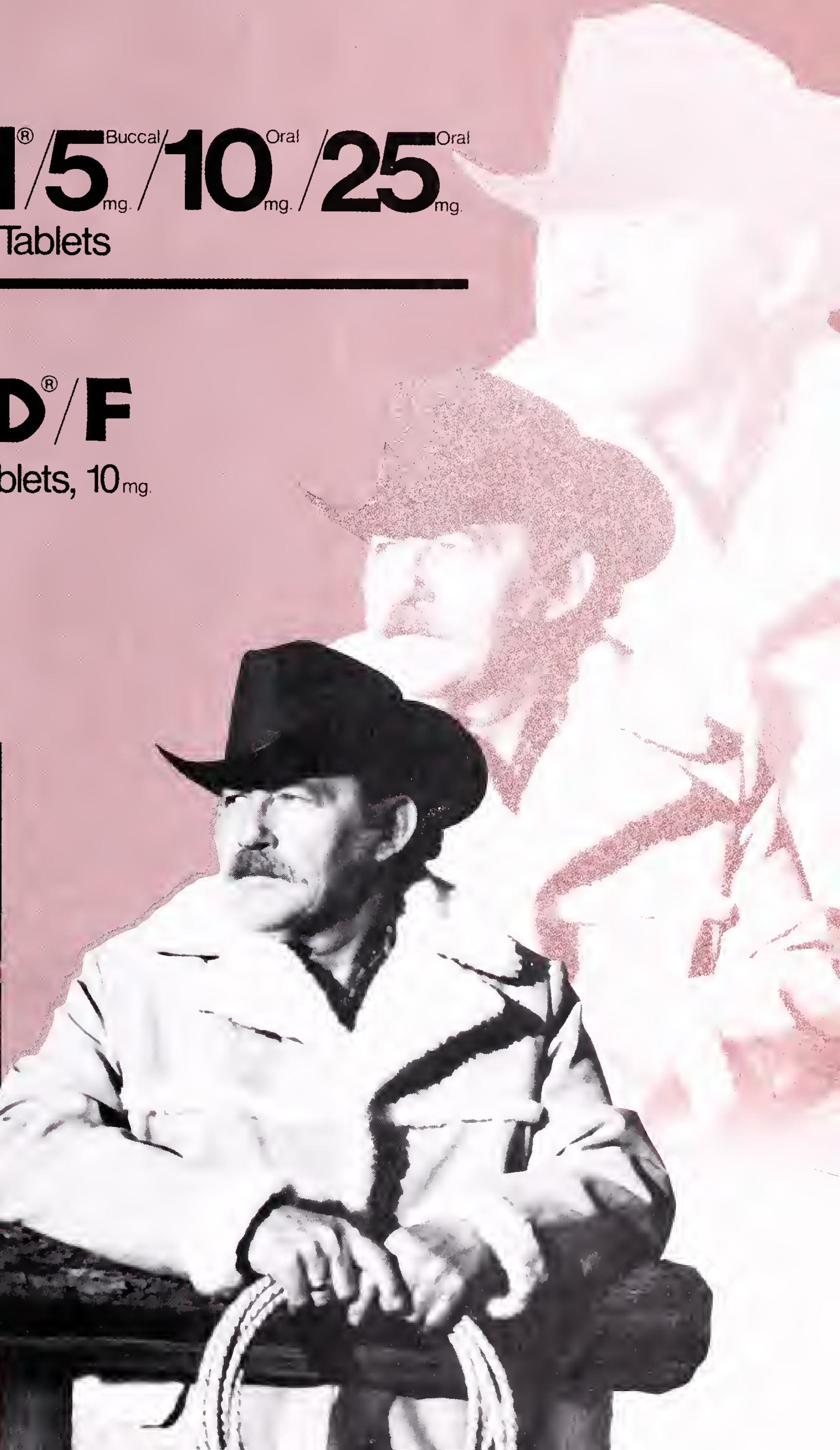
Doctor McMahon is vice president for medical affairs at Ingham Medical Center, Lansing. He also served as director of a course on DRGs at the MSMS Annual Scientific Meeting.

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android® /5 Buccal mg. /10 Oral mg. /25 Oral mg.
Methyltestosterone U.S.P. Tablets

ANDROID® /F
Fluoxymesterone U.S.P. Tablets, 10 mg.



hopes to control these latter factors with DRGs.

Figure 1 shows an actual distribution of costs, as reflected in hospital bills from January through July 1983, for patients admitted with chronic obstructive pulmonary disease to a community hospital which specializes in pulmonary medicine. The data is displayed as a frequency distribution, in which the numbers of patients experiencing each cost is plotted against each of several average costs.

This is a pretty good example of a normal distribution although, like most distributions involving health costs, it is skewed towards the direction of higher costs in a few patients. A hospital would have to treat many low-cost cases to afford the patient shown whose costs equalled $46,000.

Under the DRG system, the hospital will be reimbursed at one, fixed rate for each of its cases, regardless of how complicated or simple its mixture of patients is.

If this hospital received $4,800 for each case in this DRG, it would receive enough to pay for its case-mix and have additional money for other parts of the hospital operation. If the hospital received $2,500 for each case, it would have to make up the deficit from other operations. This particular hospital expects to receive about $4,200 for this DRG next year, and perhaps as little as $3,500 in 1986.

This example shows one of the real problems with the DRG reimbursement system. If this hospital did not specialize in caring for complicated patients, its net gain under DRGs would probably be higher than it is. DRGs penalize hospitals which care for a high proportion of patients with difficult medical problems.

What can practitioners do?

There is nothing we can do now to prevent the full implementation of DRGs, because of general public perception that medical care costs are too high, and the stated commitment of our government to control these costs. Our public stock is not very high and that of hospitals is currently no better.

There are, however, some things we can do to lessen the impact of DRGs on our patients' welfare. These include our sensitivity to the costs of providing medical care, our detection of instances of degradation of patient care and services, and our cooperation with hospitals which are trying to survive in this increased regulatory environment.

1. We must be sensitive to the costs of patient care.

The costs of medical care have fairly outstripped the rate of inflation during the last ten or more years.

To whatever extent we can reduce costs, we should do it, since the more money saved, the more will be available to provide indisputably needed care to our older patients.

2. We must provide full, timely and accurate diagnoses for medical records.

To a very large extent, the ability of hospitals to be reimbursed depends upon accurate and timely diagnoses when patients are discharged from the hospital. If you admit a patient with unstable angina for coronary catheterization, for example, and sign the patient out as "angina," the hospital will suffer. It will have incurred the greater expense for unstable angina, but be reimbursed only for a less resource-intensive diagnosis.

Never overstate the severity of a diagnosis: Charts will be audited by the HHS. But neither should you leave out diagnoses which are truthful and supported by the medical record, since these will form the basis of the coding for each chart. Of particular importance is the principal diagnosis, which is defined as that diagnosis which is determined *after discharge* to be the cause for the patient's admission.

Medical records librarians may help us to determine which diagnoses are the most appropriate ones to use in a given case by posting a checklist for our review and approval. The attending physician, however, is the one responsible for the final selection of diagnoses. The attending physician must sign off on these diagnoses before reimbursement can be requested.

3. We must be vigilant to DRGs which cause unique disadvantages to older persons.

According to the reimbursement levels described in the Sept. 1, 1983 issue of the *Federal Register*, allowances are being made for greater intensity of services provided to older persons. However, the increased rates of reimbursement are not sufficient to pay for the higher costs of caring for some of these older persons with multiple problems. To the extent that we find a significant withdrawal of support for older people with certain ailments or diagnoses, it is our responsibility to make certain our patients understand that these problems are caused by the DRG system.

In cases where patients will suffer disadvantages as recipients of health care simply because of the unfavorable provisions of the DRG system, we have a responsibility to work in the behalf of our patients to have the affected portions of the DRG system changed.

4. We must work patiently with hospitals to solve mutual problems.

It is in our combined best interest to prevent fiscal damage to the hospitals where we work and admit patients. Hospital administrators are well aware of the problem of DRGs but do not have any ready-made solutions to preventing financial harm from these regulations. Hospitals which will survive DRGs will increasingly look to their medical staff for help.

We can help in any of several ways: First, by patience with the process of discovery and change which hospitals must undergo to become more efficient. There will necessarily be changes in some services and perhaps abolition of other services, and hospitals will require our cooperation. Second, we must be alert to our own wasteful practices and that of our colleagues. Under the DRG system, waste in any area will cause shortages in another.

DIMENSION III

LOW-COST HEALTH CARE COVERAGE FROM BLUE CROSS AND BLUE SHIELD OF MICHIGAN.

Blue Cross
Blue Shield
of Michigan
SUBSCRIBER NAME
VALUED CUSTOMER
EFFECTIVE DATE OF CURRENT COVERAGE
01 01 83
GROUP NO.
94000
SERVICE CODE
1270 7007 3260
BLUE CROSS
BLUE SHIELD
BC+BS
CONTRACT NUMBER
365 036 429 0 210
BLUE CROSS OF MICHIGAN (210) BLUE SHIELD OF MICHIGAN (710) DETROIT MICH 48226

Now there's a new low-cost health care plan for Michigan State Medical Society members and their employees. It's Dimension III from Blue Cross and Blue Shield of Michigan . . . a health care plan in which the subscriber shares in the cost of the covered services. Dimension III is a lower cost alternative to the other health care plans presently available to doctors and their employees. Here's how the plan works.

Dimension III for doctors:
Deductible — $ 500 one person
$1,000 family

Dimension III for employees:
Deductible — $100 one person
$200 family

Once the deductible amount has been met, Dimension III pays 80% and the subscriber pays a 20% copayment for covered health care services. When the subscriber has paid $1,000 in copayments, no further copayments are required. Dimension III pays 100% up to $1 million. And when you select one of these plans, you'll get all the benefits that characterize the best health care coverage available:

☐ Hospital care benefits.
☐ Surgery.
☐ Maternity care.
☐ Outpatient care benefits.
☐ Psychiatric care benefits.
☐ The I.D. card that's recognized everywhere.
☐ A minimum amount of paperwork.
☐ A statewide network of Blue Cross and Blue Shield Service Centers to assist you and your employees.
☐ Worldwide coverage for you and your family.

Blue Cross and Blue Shield coverage is the choice of over 5 million Michigan residents. Why not make it your choice, too?
For enrollment information, call your local Blue Cross and Blue Shield of Michigan representative.

CAN YOU REALLY AFFORD ANYTHING LESS?

Blue Cross
Blue Shield
of Michigan

By David M. Cavataio

Physicians themselves set good health models

Physicians should establish a plan to promote health and well-being to all their patients, and not just concentrate on the sick, a husband-wife team of health education experts told an MSMS audience recently.

There are many things a physician can do in his or her practice to promote wellness, said Beth Kunzleman, president of Fitness Finders Inc., a Michigan consulting firm, and the author of several publications on aerobics.

More Important

Charles T. Kunzleman, consultant for Phillips Petroleum and YMCA on wellness, said the start for the physician is found within himself/herself. "The models you project (as a physician) are more important than words," he said.

"We all must practice what we preach," Beth Kunzleman said. "Set a good example (for your patients)."

The two spoke at a "wellness workshop" presented at the Hyatt Regency Dearborn during the 1983 MSMS Annual Scientific Meeting.

Beth, senior vice president of Living Well, and chairperson of Health Education Activities Limited, a non-profit organization to improve the health behavior of North Americans, highlighted twelve suggestions physicians can use in their daily practice:

- Forbid smoking in the waiting room.
- Place self help literature on good health in the waiting room.
- Play health video-tapes continually in the waiting room.
- Prescribe the correct balance of exercise, food, and rest to each patient.
- Encourage people to be active.
- Give office staff "well" days, not "sick" days, off.
- Put exercise bikes in the waiting room.
- Supply healthy rewards.
- Furnish alternatives to the patient on health choices.
- Present an exercise plan to the staff to be used during breaks (help manage stress in the office).
- Show patients you care by keeping track of their exercise and their progress.
- Allow patients to check the differences in their health over time, using computers programmed with the patient's progress reports.

Seven Areas

Beth, an active runner who is a secretary for the Michigan Health Council, said the seven areas of wellness study concentrat on fitness, food, weight, addictions, relationships, and spirituality.

Charles is the national program director and co-owner of Fitness Finders Inc., and the author of over 40 books on fitness, weight control, and well-being.

Louis R. Zako, MD, Dearborn Heights, MSMS president-elect and president of the Michigan Health Council, said the pair are "true experts on wellness and fitness."

The Kunzleman's and their family reside in Spring Harbor, a college town outside of Jackson, Michigan.

Mr. Cavataio is a junior in communication at Michigan State University. He is interning with the Michigan Health Council.

The AIDS Commitment

AIDS knows its business is serving physicians and their patients, who depend upon our dedication to deliver the best in diagnostic services.

AIDS ensures confidence by providing prompt, accurate and consistent testing services in a wide range of laboratory disciplines.

AIDS strives to conduct all business with integrity, skill and courtesy to each and every client.

AIDS intends to maintain excellence in skills and invest in research and development in order to better serve our clientele in the future.

AIDS understands that good service is the foundation of any business and the best service relies upon having the best people. Our staff of M.D.s, Ph.D.s, highly-skilled technologists and technicians, and AIDS' in-the-field PRO team assures the utmost in dependable, prompt, reliable service.

Allied Integrated Diagnostic Services (AIDS) is Michigan's fastest growing, most progressive full-service clinical laboratory. AIDS comprehensive diagnostic testing comprises a wide range of laboratory disciplines. We are ready to serve your laboratory needs 24 hours a day.

AIDS

ALLIED INTEGRATED DIAGNOSTIC SERVICES
22170 W. NINE MILE ROAD • SOUTHFIELD, MI 48034
313/352-5780
TOLL FREE NUMBER 1-800-AIDS LAB (243-7522)

By Gerald A. Drake, MD

Physicians and prevention of nuclear war

Nuclear war would cause the ultimate medical disaster. Naturally, this is a matter of concern and responsibility for physicians.

The first physicians' group to organize, concerning nuclear weapons and war, did so in England in the 1950s. In 1962 such a group organized in the United States, in the Boston area medical community. They became known as the Physicians for Social Responsibility (PSR).

A committee from PSR did a study on the health effects from a major nuclear attack on the Boston area. The study, published in *The New England Journal of Medicine,* showed that of about 2,750,000 people in the area, about 1,000,000 would die the first day, another million would die over the next few months, 500,000 would be injured and survive, and only 270,000 would be uninjured.

Of about 6,500 physicians in the area, two-thirds would die and only 640 would be left uninjured. This would result in each physician attempting to care for 1,700 acutely and severely injured persons, obviously an impossible task. One in seven hospital beds in the state of Massachusetts would be left. Most would be unequipped to care for major trauma and burns.

Prevention only

From such studies the group readily concluded that the only rational solution to the medical problems of nuclear war is prevention. Their primary objective became to educate the medical profession, legislators, and the public on the medical consequences of nuclear war.

Sponsors for PSR have included such prominent physicians as Herbert Abrams, former chairman of Radiology at the Harvard Medical School; Jonas Salk, discoverer of polio vaccine; Alexander Leaf, former chairman of the medical department of Massachusetts General Hospital; Bernard Lown, internationally known Harvard cardiologist; and Paul Beeson, editor of Cecil's text, to mention a few.

Out of recognition of the need for involvement of physicians worldwide, an international organization was formed called the International Physicians for the Prevention of Nuclear War (IPPNW). They held their first congress in Arlie, Virginia, in March, 1981. The preamble of the report of the proceedings says:

"Nuclear war would be the ultimate human and environmental disaster.

"The immediate and long-term destruction of human life and health would be on an unprecedented scale, threatening the very survival of civilization.

"The threat of its occurrence is at a dangerous level and is steadily increasing.

"Even in the absence of nuclear war, invaluable and limited resources are being diverted unproductively to the nuclear arms race, leaving essential human, social, medical, and economic needs unmet.

"For these reasons, physicians in all countries must work toward the prevention of nuclear war and for the elimination of all nuclear weapons."

Gravest crime

One thousand three hundred Soviet physicians attended a conference held in Moscow in December, 1982. They concluded, "... the use of nuclear weapons is the gravest crime against mankind. Nuclear war should be declared illegal and all nuclear weapons destroyed before they destroy the world ... If everyone came to understand the threat posed by these weapons and, understanding this, refused to bend to the will of those who want to use them, the threat would be abolished."

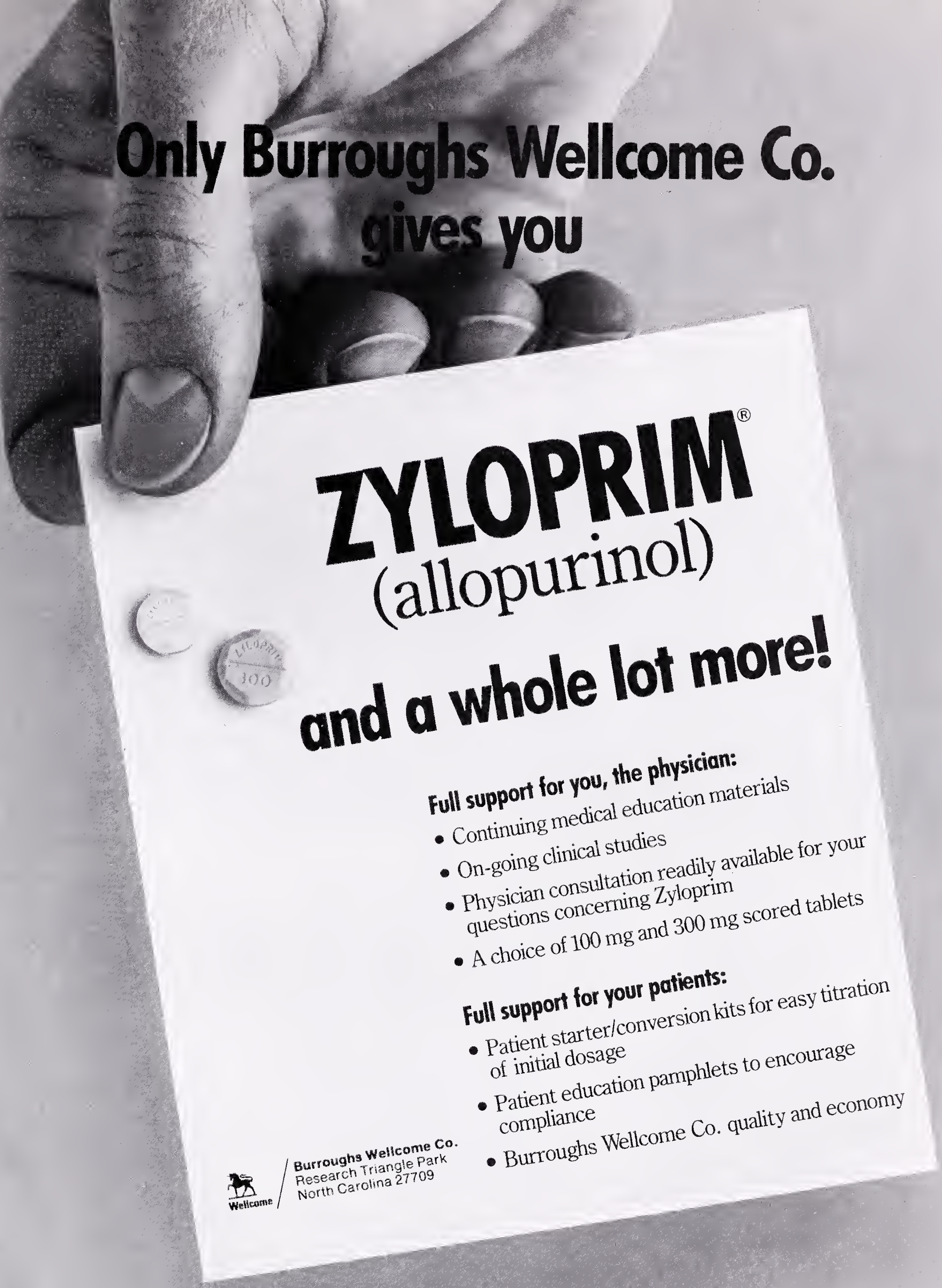
The IPPNW believes that there could be no victory for any nation in a nuclear war, that such a war could not be "limited" and that an effective civil defense is impossible. As a first step, they support a freeze on the testing, production, and deployment of nuclear weapons, and their delivery systems, in all countries.

We either must come up with an effective disarmament program, and soon, or expect an end of human existence as we know it.

British historian, Arnold Toynbee, said, "The split atom and the nation state cannot exist on the same planet." Albert Einstein said the same thing in a little different way, "The basic power of the universe cannot be fitted into the outmoded concept of narrow nationalisms."

We live on a beautiful small planet floating through space midst billions of lifeless stars. Maybe it's time to switch more of our concerns and loyalties to the planet Earth and away from nation states, if we are going to survive for long.

Doctor Drake, who resides in Petoskey, is an internist.



Only Burroughs Wellcome Co.
gives you

ZYLOPRIM®
(allopurinol)

and a whole lot more!

Full support for you, the physician:

- Continuing medical education materials
- On-going clinical studies
- Physician consultation readily available for your questions concerning Zyloprim
- A choice of 100 mg and 300 mg scored tablets

Full support for your patients:

- Patient starter/conversion kits for easy titration of initial dosage
- Patient education pamphlets to encourage compliance
- Burroughs Wellcome Co. quality and economy

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

By Judith Marr, Editor

Departicipation — the Kalamazoo story

"The big impact is on the hospital, not on physicians. Physicians can adjust. So one should not be misled."

That is one physician's down-to-earth assessment of the impact of the Bronson Methodist Hospital decision ten months ago to departicipate with Blue Cross Blue Shield of Michigan.

The Kalamazoo hospital, where 17 percent of patients were covered by BCBSM plans, severed its ties with BCBSM in February. In the ten months since, physicians, hospitals and the community have seen a number of their former givens in health care delivery undergo great changes.

With the possibility that other communities may experience the same situation (both Benton Harbor/St. Joseph hospitals departicipated as of Sept. 1, and St. Mary's of Escanaba has not participated in years), *Michigan Medicine* presents the following review of the Kalamazoo situation from the physicians' point of view. Administrators at both hospitals declined to comment at the time of this writing.

The physician who talked so straightforwardly above is James Dolan, MD, radiation oncologist and president-elect of the Kalamazoo Academy of Medicine. He and current Academy President B. David Wilson, MD, allergist, reflected over dinner one evening recently.

Looking ahead

Doctor Dolan felt the changes are no more than "a pain in the neck," while Doctor Wilson summarized them to date as "a tempest in a teapot." Doctor Wilson was looking ahead to the much greater changes which will occur when the diagnostic related group (DRG) reimbursement system is put in place for Medicare patients.

Ultimately, agreed both physicians, it is the patients who suffer the severest effects of the departicipation. Their experience in Kalamazoo is that BCBSM-covered patients and physicians have shifted their business to the hospital (Borgess Medical Center) which will accommodate their insurance company. And the shift, they said, has caused inconvenience primarily for the patients.

The physicians pointed out, however, that some reported changes in Kalamazoo actually only exist in the public's perceptions.

"What the decision has done in the non-participating hospital," says Doctor Dolan, "is cause the Blues to send their dollars to the patient, instead of to the doctor. The insurance process is so confusing for the patients, that they often put the money in the bank; they don't know what to do with it.

"Then, the patients get a bill for the remaining charges. They think because Bronson doesn't participate with the Blues, that the Blues didn't pay anything. Of course that's not true, and it's their *perception* that isn't right.

"But all you have to do is have each patient describe their misconceptions to 10 more persons, and bingo! You've got a problem."

"Patients, particularly older Medicare recipients," observes Doctor Dolan, "are uniquely concerned about the cost of health care. The younger patients are less concerned as their insurance tends to cover everything."

Some Kalamazoo physicians reported that their patients requested treatment at Borgess, "where they accept insurance." Again, patients had an incorrect perception of the situation, thinking that Bronson accepts no insurance company's coverage. But this "perceived change" has brought about some medical care delivery changes, resulting in shifts in the hospitals' patient loads.

Patients worried about having to pay the entire cost of their health care because the hospital no longer participates with BCBSM now ask to be cared for at the remaining participating hospital in the city, Borgess Medical Center.

In addition, point out Doctors Dolan and Wilson, physicians have run into difficulties which have caused them to transfer their medical care delivery to the participating hospital.

Doctor Dolan provides some insight into the difficulties physicians have faced since the Bronson depar decision.

"The biggest problems relate to scheduling, to waiting for admissions and surgery, to patient's emotional discomfort and inconvenience," he says.

Major changes

Doctors Dolan and Wilson canvassed their colleagues prior to their dinner discussion. They uncovered a number of adjustments to the BCBSM depar decisions related to the physician's specialty.

Major changes have taken

Bronson Hospital

place among the obstetricians and gynecologists. Most of them traditionally have been based at Bronson Hospital, which has the city's only neonatology unit. And because most OB-GYN patients are younger, there is a higher concentration in those practices of BCBSM coverage.

"There has been a definite shift of obstetrical-gynecological patients to Borgess as a result of the depar decision," says Doctor Wilson. The Borgess Hospital specialists have been primarily affected, and report difficulties in scheduling operating room time, where once they had little competition.

General surgeons have not had many problems with the new arrangement, Doctors Wilson and Dolan report. They have seen increased surgical loads at Borgess and some scheduling problems, particularly with elective surgery.

"Kalamazoo OB-GYNs report it is more difficult to spread themselves between two hospitals when patients are in labor," says Doctor Wilson. "This is particularly true for solo practitioners, many of whom find it physically impossible to be at two hospitals at the same time."

Kalamazoo pediatricians, like the city's obstetricians/gynecologists, traditionally have been based primarily at Bronson Hospital.

They, too, now have patients at both hospitals, and worry about covering more ground. "Everything has been okay this summer, but they worry if enough beds will be available in the cold months when respiratory and gastrointestinal tract infections are rampant," says Doctor Wilson.

Currently there are residents to help in pediatric intensive care units at both hospitals.

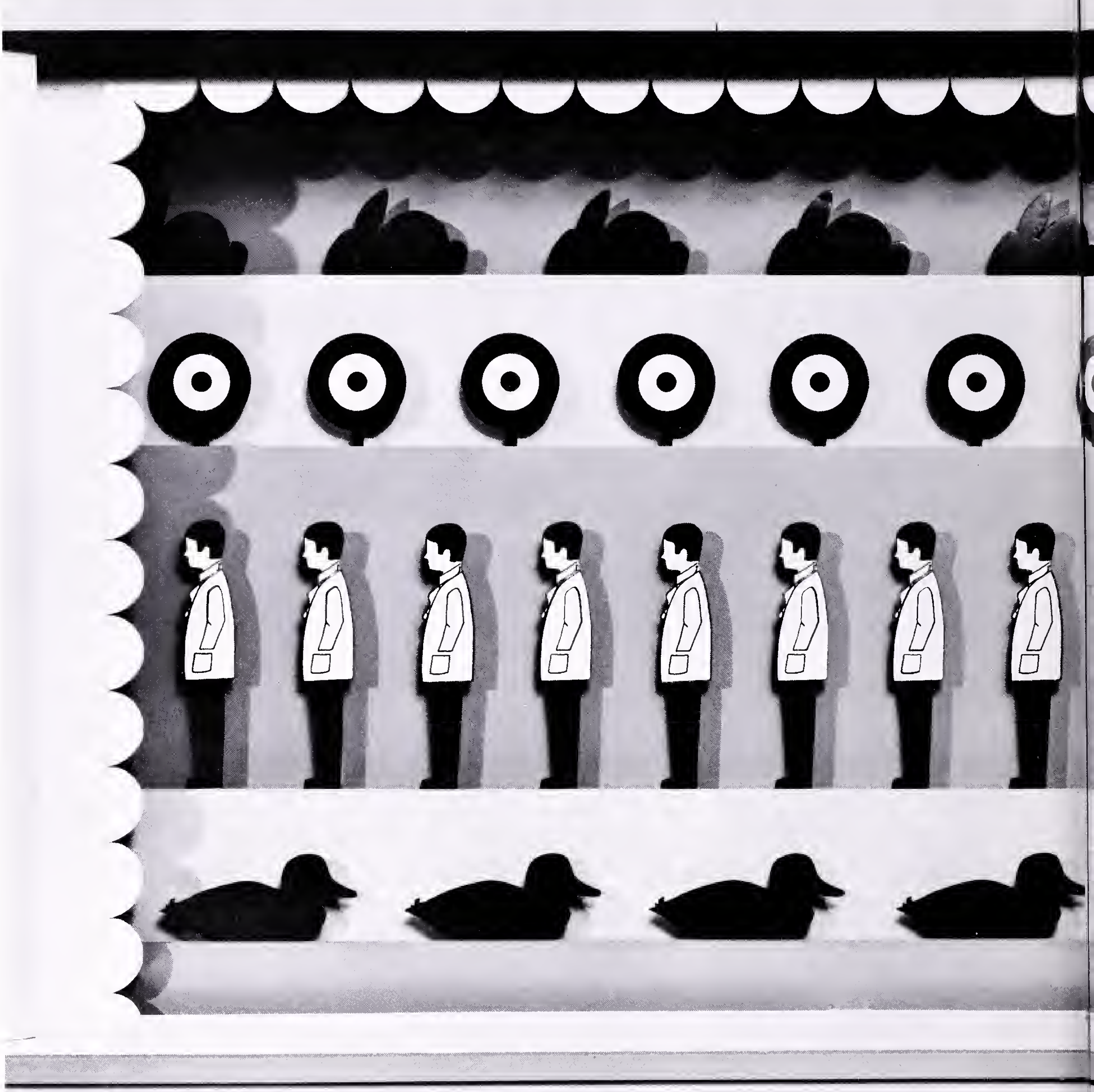
"But if we don't have them, physicians will have to be in both places. This is inconvenient, and mainly just causes a change in the physician's lifestyle," acknowledges Doctor Wilson. "But it also has an effect upon medical care delivery."

"It really does," adds Doctor Dolan. "If you have to go to two hospitals instead of one, you've added another hour to your hospital schedule. It can really cut into your office hours.

Ophthalmologists and pathologists report more business at Borgess.

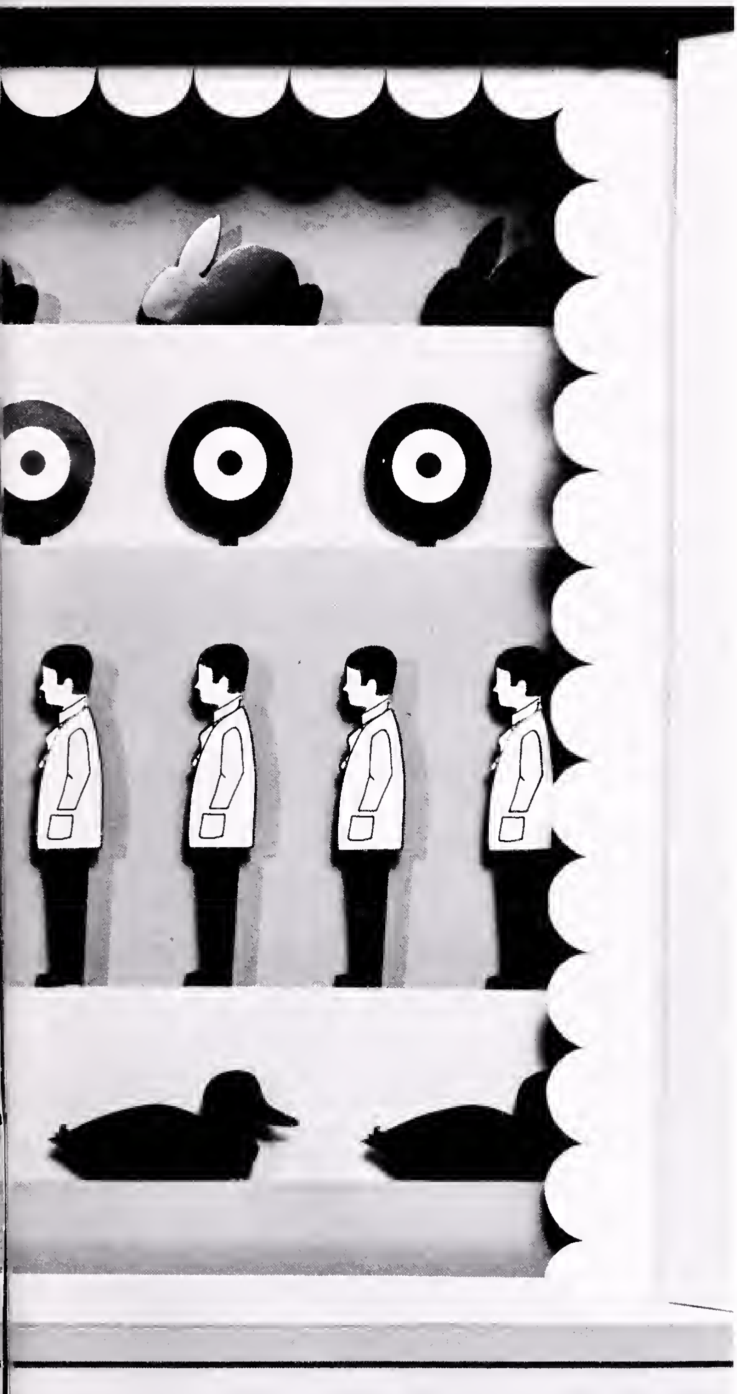
Continued on page 20

If you become the target of a



983 MPMLC

professional liability claim...



You will be glad you have Michigan Physicians.

Michigan Physicians has been solving complex medical professional liability problems since 1976. With the state's largest and most experienced claims staff, Michigan Physicians works with you to resolve claims (and incidents) that most physicians have never faced in their careers.

In a changing legal environment, you need the best coverage you can buy because the risk of a professional liability claim is becoming greater every day.

For a confidential rate quotation and more information about Michigan's leading physician-owned insurance company, call or write the office in your area.

Michigan Physicians
Mutual Liability Company

1305 Abbott Road
East Lansing, MI 48823
(517) 351-1150
(800) 292-1926

6735 Telegraph Road
Suite 205
Birmingham, MI 48010
(313) 647-5550

Endorsed by the Michigan State Medical Society

Public relations

"If a surgeon works at both hospitals it's a matter of scheduling for admissions and the OR," says Doctor Dolan. "This is a major problem to the patients. Americans are not geared to waiting for medical procedures."

More public relations efforts are needed, observed the doctors, as physicians must reassure their patients that they work at both hospitals.

There are rumors, according to the doctors, that Bronson and BCBSM are in negotiations.

"If Bronson and the Blues are talking, maybe the effect is stronger than the hospital expected."

Bronson, Borgess talking with Blues

Bronson Hospital administrators are talking with Blue Cross Blue Shield of Michigan, according to Bronson Past Chief of Staff Gary D. Maynard, MD. That is despite the Bronson decision to departicipate with BCBSM, says Doctor Maynard, who also is chairman of the MSMS Committee on Medical Staff Relations.

"We aren't backing down," says Doctor Maynard. "We feel we should be paid billed charges the same as by any other company."

Though others in the Kalamazoo physician community only speculate that hospital/BCBSM dialogue was continuing following the February breakup of the two, Doctor Maynard confirms that the talking has continued.

"There never was a point when anyone said they wouldn't talk—it's been going on all along."

BCBSM has continued to reimburse physicians for services delivered in Bronson's neonatal intensive care unit, as it's the only one in town.

Something done

Doctor Maynard reports there is a push on the part of the hospital administrators to "get something done on the part of BCBSM" for the city's obstetricians/gynecologists. As the group that has borne the brunt of the departicipation decision, they have asked that something be done, he says.

"I feel for them," says Doctor Maynard, reiterating those specialists' problems in suddenly having to spread themselves between two hospitals. Previously, most obstetrical and gynecological work was done at Bronson. Those patients are BCBSM policyholders in greater proportions, and now must be treated at Borgess Hospital if traditional insurance company reimbursement is to be forthcoming.

"I think something will be done for them," continues Doctor Maynard. "The situation won't stay at ground zero."

Doctor Maynard confirms that Bronson has lost business as a result of the departicipation decision. He estimates the drop at around five to six percent.

"Bronson has done very well economically," however, he says. "We still are ahead of last year's budget."

A large number of Kalamazoo-area businesses and employers dropped BCBSM coverage following the hospital decision, says Doctor Maynard. Another effect has been a "multitude" of letters to the hospital from the business community congratulating the hospital on its decision. The labor unions with General Motors plants in the area, however, he says, have been "very much against this decision."

Borgess talking

Borgess Hospital has not been altogether happy with the increase in their Blues patients either, says Doctor Maynard. "They now have a higher percentage of their patients for which they are being reimbursed only 70 percent of charges.

"We understand that they are renegotiating their contract with the Blues," he says.

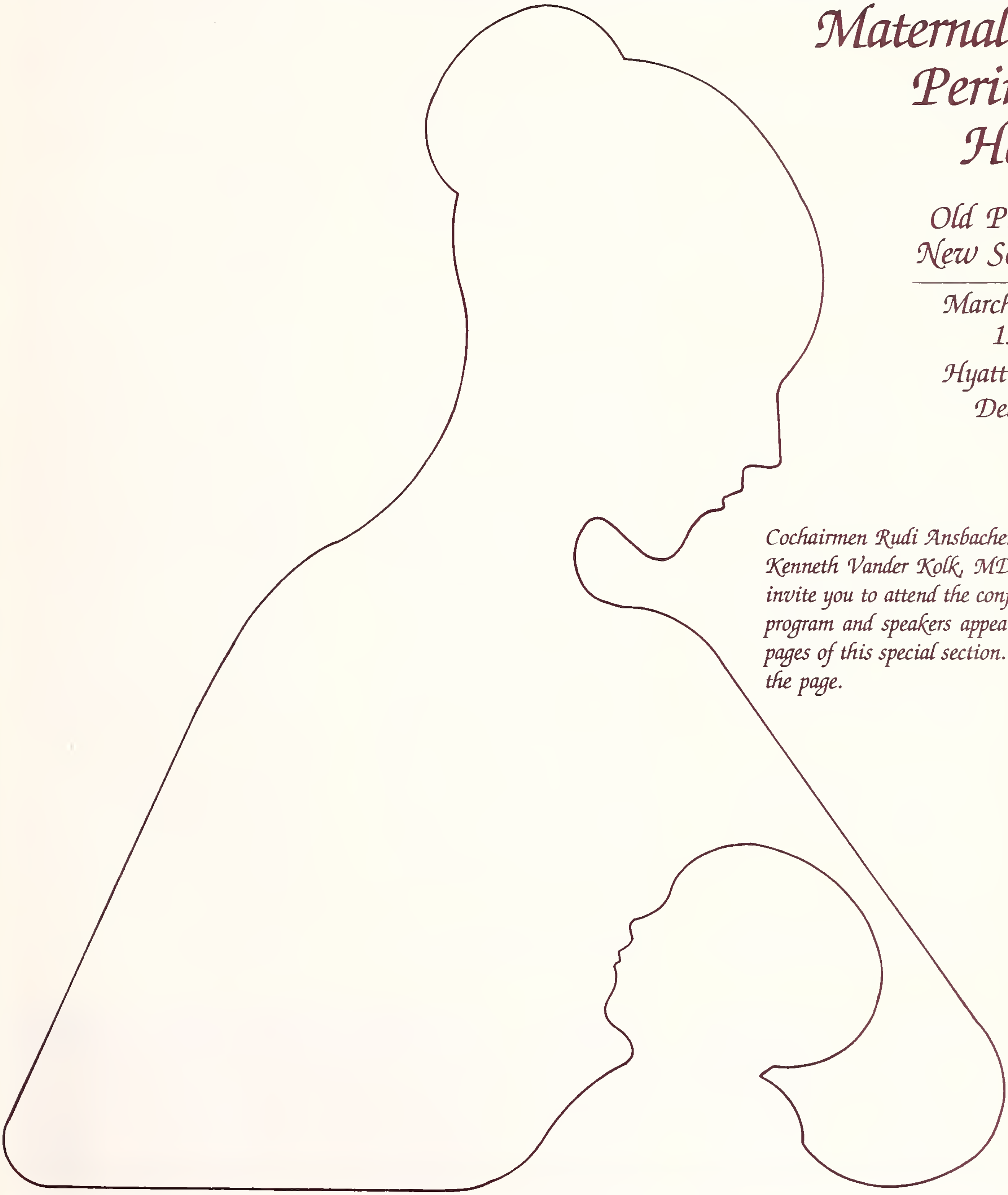
The two hospitals remain very competitive, Doctor Maynard reports. "To date the only thing we've been able to cooperate on is our educational programs.

"It's not that we doctors haven't tried," he says. "The biggest problem, in all honesty, in trying to get the two hospitals together is third parties. We have to fight just to maintain the status quo in the face of all the government intervention."

23rd Annual
Michigan Conference on Maternal and Perinatal Health

Old Problems, New Solutions

March 28-29, 1984
Hyatt Regency
Dearborn



Cochairmen Rudi Ansbacher, MD, and Kenneth Vander Kolk, MD, cordially invite you to attend the conference. The program and speakers appear on the pages of this special section. Please turn the page.

For details: Michigan State Medical Society, PO Box 950, East Lansing, MI 48823 (517) 337-1351

Conference program, speakers and their topics

Wednesday Morning

Moderator: Kenneth J. VanderKolk, MD, Grand Rapids

8:30 to 9:15
"Family-Centered Perinatal Care"
Charles E. Flowers, MD, Professor and Chairman, Department of Obstetrics and Gynecology, University of Alabama in Birmingham

9:15 to 10:00
"Vaginal Delivery After C-Section"
Justin P. Lavin, MD, Chief, Division of Obstetrics, and Head, Maternal/Fetal Medicine Service, Akron City Hospital, Co-Director, Akron Regional Perinatal Center, Akron

Properly conducted vaginal delivery after cesarean section is relatively safe. Of those patients allowed a trial of labor, 66.7% were successfully delivered vaginally. A policy of selective vaginal deliveries after prior cesarean sections results in cost reduction.

10:00 to 10:15
Question and Answer Period: Doctors Flowers and Lavin

10:15 to 10:45
Break

10:45 to 11:15
"Diabetes and Pregnancy"
Bruce A. Work, Jr., MD, Professor and Director of Maternal/Fetal Medicine, University of Illinois at Chicago

Aggressive management and meticulous control are the keystones of care for diabetes and pregnancy. Preconceptual treatment should reduce birth defects.

11:15 to 11:45
"Infant of the Diabetic Mother"
Mary P. Bedard, MD, Assistant Professor of Pediatrics, Wayne State University School of Medicine, and Associate Neonatologist, Children's Hospital of Michigan and Hutzel Hospital, Detroit

Infants born to diabetic mothers (IDM) are at increased risk of developing numerous problems. Strict maternal glycemic control has reduced the incidence and severity of prematurity and hyaline membrane disease. Metabolic problems such as hypoglycemia are easily detected. Cardiomyopathy is present in 20-50% of IDMs. Congenital anomalies are probably the leading cause of morbidity and mortality in these infants.

11:45 to 12:00
Question and Answer Period: Doctors Bedard and Work

12:15 to 1:45
Luncheon Meetings

"Counterpoints to Family-Centered Perinatal Care"
Dietrich W. Roloff, MD, Associate Professor of Pediatrics and Communicable Diseases and Director of Newborn Services, University of Michigan, Ann Arbor

A review of the interaction of society and individuals, consumers and health professionals around childbirth will be presented. The participants are invited to discuss their own views and experiences of changing care patterns regarding, "Birthing: Truth versus Social Customs."

"Is That Fetus Growth Retarded?"
Robert J. Sokol, MD, Chairman, Department of Obstetrics and Gynecology, Wayne State University School of Medicine, Detroit

Intrauterine growth retardation continues to be associated with increased perinatal mortality and morbidity, as well as long term neuro-behavioral abnormalities. The majority of cases remain undiagnosed prenatally. The use of history, physical, and laboratory assessments to assist in the diagnosis of intrauterine growth retardation will be discussed.

"Recognition of Intrauterine Asphyxia"
John W. Goldkrand, MD, Director, Maternal/Fetal Medicine and Obstetrics, Associate Professor of Obstetrics and Gynecology, Albany Medical Center, Albany, NY

Antepartum and intrapartum monitoring techniques to detect intrauterine asphyxia will be discussed, including electronic fetal monitoring and fetal scalp pH sampling.

"Diagnosis of Perinatal Infections"
John H. Grossman, III, MD, As-

Barr

Bedard

Beer

Bowerman

Cram

Donn

sociate Professor of Obstetrics, Gynecology, and Microbiology; Director, Division of Maternal/Fetal Medicine, Department of Obstetrics and Gynecology. The George Washington University School of Medicine and Health Sciences, Washington, DC

"Stabilization and Transport of the High Risk Neonate"
Rochelle Igrisan, RN, MSN, Northern Michigan Hospitals, Inc., Petoskey

Wednesday Afternoon

Moderator: Robert J. Sokol, MD, Detroit

2:00 to 2:45
"Premature Rupture of Membranes"
John H. Grossman, III, MD, Associate Professor of Obstetrics, Gynecology, and Microbiology; Director, Division of Maternal/Fetal Medicine, Department of Obstetrics and Gynecology, The George Washington University School of Medicine and Health Sciences, Washington, DC.

Since 1976, obstetrical patients with preterm premature rupture of the membranes have been managed according to a standardized protocol. Labor is induced in pregnancies beyond 33 gestational weeks following a 12 hour latent period. Antibiotics, tocolytics, and steriod induction of pulmonary maturation are not routinely employed. The maternal and neonatal outcomes of pregnancies managed in this fashion will be summarized.

2:45 to 3:30
"Host Defense Mechanisms In Obstetrics"
William Johnson, PhD, Professor, Department of Microbiology, University of Iowa College of Medicine, Iowa City

Amniocentesis provides a mechanism by which bacteria may be introduced into the amniotic fluid, bypassing traditional barriers to infection. In addition, it is now clear that bacteria may invade amniotic fluid by the ascending route in the presence of intact fetal membranes. It is therefore essential to understand the defense mechanisms of the fetal environment.

3:30 to 3:45
Break

3:45 to 4:30
"Drug Use During the Perinatal Period"
William Rayburn, MD, Associate Professor and Chief, Perinatology, Department of Obstetrics and Gynecology, University of Michigan Medical School, Ann Arbor

Despite therapeutic restraints, pregnant women continue to take prescription, over-the-counter, and illicit drugs before, during, and after birth. Current recommendations about commonly taken drugs are proposed.

4:30 to 5:00
Question and Answer Period: Doctors Grossman, Johnson, and Rayburn

Thursday Morning

Moderator: Ralph A. Cram, MD, Albion

8:30 to 9:30
"Sexuality and Pregnancy"
Juanzetta S. Flowers, RN, MA, Assistant Professor of Nursing, Department of Obstetrics and Gynecology, University of Alabama in Birmingham
Charles E. Flowers, MD, Professor and Chairman, Department of Obstetrics and Gynecology, University of Alabama in Birmingham

An overview of the impact of pregnancy upon the female and

Participating organizations

The Michigan State Medical Society, and its Committee on Maternal and Perinatal Health are proud to present the 23rd annual Michigan Conference on Maternal and Perinatal Health. Participating organizations are:

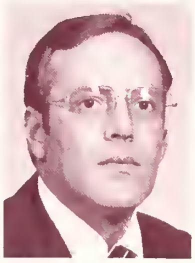
Michigan State Medical Society
Michgian Academy of Family Physicians
Michigan Chapter, American Academy of Pediatrics
Michigan Department of Public Health
Michigan Nurses Association
Michigan Section, District V, American College of Obstetricians and Gynecologists
Michigan Section, Nurses Association, American College of Obstetricians and Gynecologists
Perinatal Association of Michigan

C. Flowers

J. Flowers

Goldkrand

Grossman


Johnson

Klemsczak

the couple's sexuality will be given. A practical approach to prenatal care, in light of this impact, will be discussed.

9:30 to 10:15
"Nurse Midwifery: A Paradigm for Health Care"
Joyce E. Thompson, CNM, Dr.PH, FAAN, University of Pennsylvania, School of Nursing, Philadelphia

This presentation will define the current practice of nurse-midwifery in the United States and discuss the need for mature, professional relationships in order to meet the health needs of childbearing families.

10:15 to 10:45
Break

10:45 to 11:30
"Pregnancy-Induced Hypertension"
Bruce A. Work, Jr., MD, Professor and Director of Maternal/Fetal Medicine, University of Illinois at Chicago

The etiology of pre-eclampsia remains undetermined; however, rigorous perinatal care can improve perinatal results.

11:30 to 12:00
Question and Answer Period: Doctors Flowers, Thompson and Work and Mrs. Flowers

12:15 to 1:45
Luncheon Meetings

"Sonography of Fetal Anomalies"
Richard A. Bowerman, MD, Assistant Professor of Radiology, University of Michigan Medical School, Ann Arbor

The use of sonography to evaluate fetal anomalies will be described.

"Neurologic Sequelae of Asphyxia Neonatorum"
Steven M. Donn, MD, Assistant Professor of Pediatrics, Section of Newborn Services, University of Michigan Medical School, Ann Arbor

Asphyxia neonatorum continues to be the leading cause of neuro developmental handicaps among infants born at term. Central nervous system manifestations of asphyxia include hypoxic-ischemic encephalopathy, neonatal seizures, and long-term sequelae such as cerebral palsy.

"Antepartum Rh Immune Globulin"
Alan E. Beer, MD, Professor and Chairman, Department of Obstetrics and Gynecology, University of Michigan Medical School, Ann Arbor

The benefits and hazards to the patient of antepartum Anti D IgG administration will be discussed. Cost-benefit analyses will be presented.

"Nurse Midwifery: Models of Practice"
Joyce E. Thompson, CMN, Dr.PH, FAAN, University of Pennsylvania, School of Nursing, Philadelphia

The philosophical, legal, and economic issues surrounding nurse-midwifery and alternative birthing options in private, group, or other entrepreneurial type of practice will be discussed.

"Early Discharge of the Mother and Infant"
Mary M. Conklin, RN, MSN, Maternal Health Nurse Consultant, Michigan Department of Public Health, Lansing
Jeannette Klemsczak, RN, Detroit Regional Office, Michigan Department of Public Health

Thursday Afternoon

Moderator: Rudi Ansbacher, MD, Ann Arbor
"Fetal Surgery: Pros and Cons"

2:00 to 2:45
"The Case for Fetal Surgery: An Option for Selected Patients"
Kevin C. Pringle, MB, ChB, Associate Professor of Surgery (Pediatric), Department of Surgery, University of Iowa Hospital and Clinics, Iowa City

Fetal diagnosis is rapidly approaching the point where it is becoming possible to consider invasive therapy for a variety of congenital anomalies. Options will be discussed against the background of the ethical issues raised, especially the inevitable conflict between the fetus' right to needed therapy and the mother's right to refuse therapy for that fetus that is predicated upon a surgical procedure performed on her.

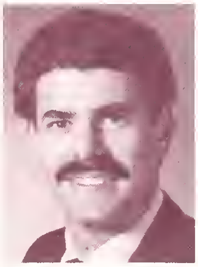
2:45 to 3:30
"The Case Against Fetal Surgery: Over-enthusiastic Application"
Mason Barr, Jr., MD, Professor of Pediatrics, Director of the Teratology Unit and Director of the Myelodysplasia Rehabilitation Unit, University of Michigan School of Medicine, Ann Arbor

The risks of over-enthusiastic application of in utero intervention for the malformed fetus are great. Few types of malformations are amenable to fetal surgery and few of those warrant intervention attempts. Truly successful surgery demands diagnostic precision, thorough knowledge of the biology of maldevelopment and technical expertise not generally available.

3:30 to 4:00
Question and Answer Period: Doctors Barr and Pringle

4:00
Conference Adjourns

Pringle

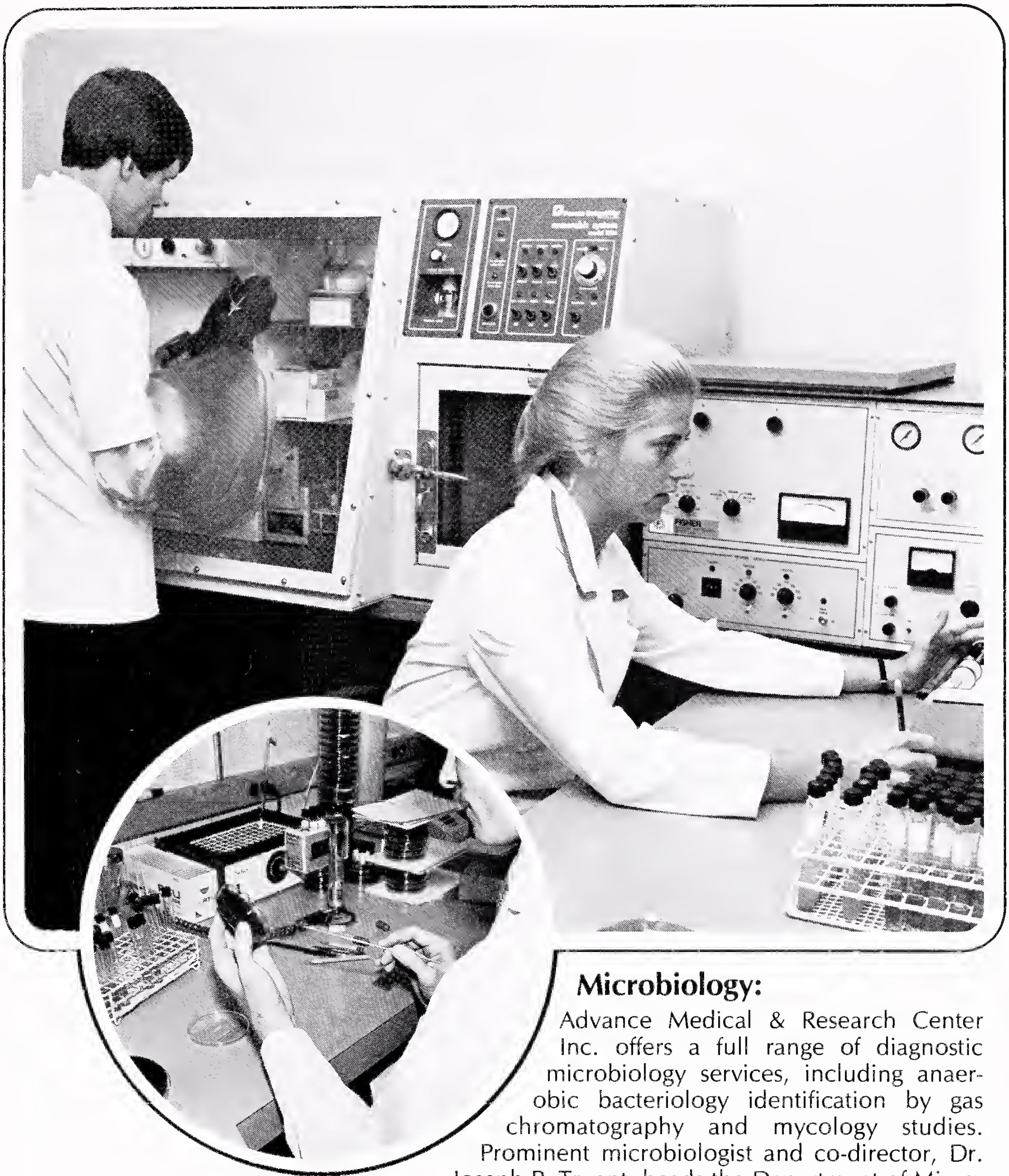

Rayburn

Roloff

Sokol

Thompson

Work



Microbiology:
Advance Medical & Research Center Inc. offers a full range of diagnostic microbiology services, including anaerobic bacteriology identification by gas chromatography and mycology studies. Prominent microbiologist and co-director, Dr. Joseph P. Truant, heads the Department of Microbiology.

Advance Medical & Research Center, Inc.
1270 Doris Rd. • Pontiac, Michigan 48057 • (313) 373-9120
Branches: Allen Park, Alpena, East Jordan, Flint,
Grand Rapids, Kalamazoo, Lansing, Monroe, Traverse City

Serving the medical profession since 1963

④

By Katharine S. Brown

Mutual funds — diversification, participation, appreciation

For various reasons, mutual fund investing has been regarded as unsophisticated, boring and inactive. However boring it may be, the results of many stock mutual funds have been astounding over time, in good and bad stock markets.

There is a mutual fund organized for nearly every investment strategy. Consider the following: common stocks, preferred stocks, corporate bonds, government bonds, tax-exempt bonds, U.S. Government securities, GNMAs, money market instruments, options, gold shares, international securities, financial future, and more are the foci of mutual funds' strategies. In addition, you may diversify by owning several funds in a fund family. There are ways to take advantage of bull markets, bear markets and trendless markets. You can, for instance, employ market-timing devices, fundamental analysis, or be a chart watcher as a mutual fund member. There is no reason to be inactive unless you wish to be.

Long-term

Obviously, mutual funds are better suited to the long-term investor than to the short-term trader. I often suggest them for my very large accounts — pension and profit sharing, or for my customers with less than $10,000 to invest.

One of the primary reasons stockbrokers suggest investing in certain mutual funds has been their superior, long-term record. Professional management, lower cost and broad diversification are all additional virtues of well-run mutual funds.

A few suggestions — put the core of your fund investment in a well-known, well-managed family of funds that offers unlimited, free switching among its various funds. You might select two families to provide additional diversification: one that has a better-than-average equity performance and another than offers more specialized funds, such as options, international securities, high-tech stocks, or gold.

Next, let your broker know that you want to be active and informed. You need not be concerned about daily market average, but should be aware of major market shifts and interest-rate trends. These concerns influence your decision to make new and continuing purchases and whether you should shift your present holdings in or out of equities.

Let's look at an obvious case. Assume that in August, 1982, you were parked in money-market funds and enjoying double-digit rates. Money funds were at their peak, equity funds at a low ebb. The Standard and Poor's 500 was trading at about one times book value. It was a classic situation for a big switch to equity funds. If your money fund had been part of a family, you could have been in the market in 24 hours. True, it's easy to look back now with intellectual hindsight. Most of us sat on the sidelines for a while to see if it really was a bull market. Nevertheless, the signs were there and so was the opportunity for fund buyers.

Here is another example of intelligent mutual fund investing. You're self-employed, earning a six-figure income, and you want a high after-tax yield on fixed-income investments. You purchase a municipal bond fund yielding about nine and a half percent.

Perhaps, in your bracket that is equivalent to a taxable yield of 19 percent. At the beginning of next year, your accountant informs you that because of a recent fire at your business establishment, you will have no taxable income for the calendar year.

Your tax-exempt investment isn't too attractive now. If your fund is part of a family of funds, you can make a switch from the tax-exempt bond fund to a high-yielding taxable bond fund at no cost in 24 hours. Next year, after the tax loss is absorbed, you may switch back to the tax-exempt fund at no cost. This switch usually can be accomplished with a phone call to the fund.

Chances excellent

Buy a stock mutual fund and forget about it for a few years. Have the capital gains and dividends re-invested. The mutual fund management will buy you shares in good and bad markets, at lower prices and higher prices. Your chances of a rate of return exceeding anything in the fixed-rate area over time are excellent.

Indeed, a well-managed fund will exceed the Standard and

Continued on page 28

Ms. Brown is an account executive with Prescott, Ball and Turben, investment banks and brokers, East Lansing. She is consultant to the MSMS Board of Managers on the investment of the MSMS capital and creative reserve funds assets.

YOUR
INCOME
Employees' Salaries
OFFICE RENT
Utilities

COULD YOU MAINTAIN YOUR OFFICE EXPENSES DURING A PERIOD OF DISABILITY?

At age 40, your chances of becoming disabled for up to 6 months are 1 out of 3...1 out of 5 could be disabled up to 2 years...1 out of 7 could be disabled up to 5 years.*

You've probably insured your own income, but what about your employees' salaries, your office rent, your professional liability premiums, etc. etc. Check these features of the Professional Overhead Expense plan sponsored by the MSMS.

- ☑ Up to $3,000 monthly benefit
- ☑ Waiver of Premium
- ☑ Survivors' Benefits
- ☑ Professional liability premiums are a covered expense
- ☑ Expenses covered include rent, utilities, employees' salaries, accountant services, plus many more

"we're here to help"

Stratton–Cheeseman & Associates, Inc.
1305 Abbott Road • P.O. Box 1563 • East Lansing, Michigan 48823
Call Toll Free: **800-292-1966**

*1979. The National Underwriter Company

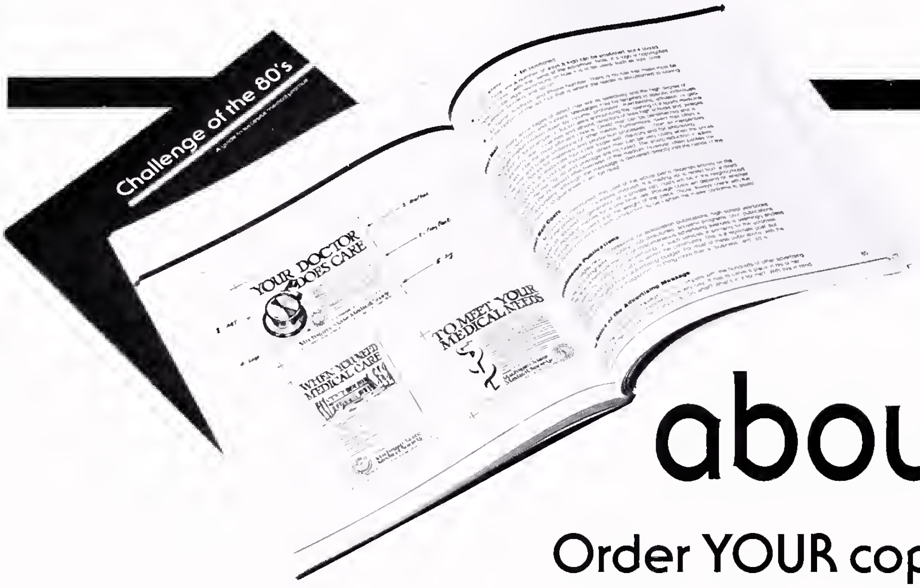
Poor's 500 averages annually. Find a fund family that has several equity funds that have consistently outperformed the S & P 500, and you increase your odds for a superior rate of return over time.

Here are some other things to bear in mind. Many funds are "loaded." The mutual fund in this case prefers that the brokerage house market their product — while the mutual fund personnel strictly manages the assets of the fund. That sales charge can be reduced by quantity discounts, cumulative purchases from people in the immediate family, a letter-of-intent agreement which permits sales charge reduction on purchases agreed to over a 13-month period.

Overall, mutual funds are an attractive investment choice for the knowledgeable investor, the new investor, the large investor, the small investor, or the investor who doesn't have the time or expertise to make daily investment decisions.

IRAs, Keoghs, pension and profit sharing plans, education plans, custodial accounts for minors, all involved monies suitable for mutual fund investment.

Perhaps now is the time to begin to *participate* in the stock market by being instantly *diversified* into several stocks hoping for above average *appreciation* through the use of mutual funds.



Be wise about the 80's

Order YOUR copy of this book today!

Practice management, second of the four-part series in the MSMS "Challenge of the 80s" book, takes the reader through a lifetime of medical career planning. It begins with such rudimentary considerations as solo versus group practice, lease-buy options, and incorporation, noting trends and debating various advantages and drawbacks.

Running an efficient work-a-day office is the main theme. Timely sections discuss appointments, fees, billing, collections, purchasing, controls and safeguards, and computers. Employee selection, motivation, management and termination are reviewed at length. The prudent use of consultants and advisors (such as accountants and attorneys) is addressed, as well as relationships with patients, other physicians and hospitals. The importance of formulating and enunciating clear office policies, procedures and positions is emphasized.

Finally, a brief dissertation on investment and retirement goals is appropriately included.

Full of nuts and bolts practicality, this rich, concise text is typical of the quality of the entire volume, *Challenge of the 80s; A guide to successful medical practice.* Well conceived and executed, it is a book to acquire, read and use in your practice.

Frederick W. Bryant, MD
MSMS District Director

Please send me ____ copy(ies) of *Challenge of the 80s: A Guide to Successful Medical Practice.* Enclosed is my check for $____ ($5 x number of copies, or $15 x number of copies if non-member).

Name ____________________

Address ____________________

____

City ____________________ Zip ____________________

MSMS, 120 W. Saginaw, East Lansing, MI 48823

Newborn hearing

The incidence of severe hearing loss in newborns has been reported by various screening programs as being approximately one per 1,000. In infants requiring intensive care in the newborn period, however, the incidence of severe hearing loss increases to approximately one in 50.

Because of the significant effects of sensory deprivation associated with deafness, a well organized program for effective screening, confirmatory diagnosis, and treatment is essential.

The Crib-O-Gram unit is a screening device widely used to determine hearing acuity and, since the spring of 1980, it has been used in the nurseries at Holden NICU, University of Michigan Medical Center, as a primary tool in screening high risk infants.

However, researchers have noted a very high false positive rate, resulting in a need for frequent retesting, and high parental anxiety. These, coupled with the length of the test (average of three hours), cause the program to be less cost effective. In addition to the high false positive rate, there also exists a certain percentage of false negatives.

A team including Raul C. Banagale, MD, and Charles A. Tait, PhD, presently is conducting a demonstration project designed to expand and broaden the scope of current procedures in hearing screening of high risk newborns at Holden. The goals of this new program are to: (1) extend our testing ability beyond the Crib-O-Gram screening; (2) evaluate the utilization of brainstem evoked response audiometry; (3) improve the follow-up of the infants with suspected hearing loss and (4) strengthen the interactions among interested specialists within our medical center while developing a statewide model for early detection and remediation of hearing impairment in infants.

The research team is seeking an eventual statewide screening program for hearing loss in infants.

Bone repair

A preliminary animal study reported Nov. 30 suggests that prostaglandin E_2 may prove helpful in improving fracture healing and bone repair.

The report was presented at the American College of Veterinary Pathologists meeting in San Antonio by Wanda B. High, DVM, PhD, associate research veterinary pathologist, The Upjohn Company.

"Healing of rib fractures in dogs treated with prostaglandin E_2 in this study tends to suggest a relative increase in fibrocellular, cartilagenous and boney callus compared to control animals," says Doctor High.

NMR available

Medicine's highest technology — nuclear magnetic resonance (NMR) scanning — will be available within the coming year for research and clinical use at Michigan State University, following approval recently by the MSU Board of Trustees of an internal loan of $2 million.

The loan approval paves the way for MSU's Department of Radiology, a unit of the College of Human Medicine and College of Osteopathic Medicine, to purchase two nuclear magnetic resonance scanners. One will be used for patient diagnoses, on a selective basis, in MSU's Clinical Center and the other for additional research on NMR imaging.

Calcium stops cancer

Wayne State University scientists Nov. 30 announced at the annual meeting of the American Society of Cell Biology in San Antonio that certain calcium channel blockers prevent the spread of cancer in animals.

Calcium channel blockers are used successfully in humans for the treatment of a number of cardiovascular disorders and their toxicity is low. Calcium ions function as messengers and regulating agents to control many functions of the body.

Organic calcium channel blockers are highy specific and can exert their effects at extremely low concentrations by selectively blocking calcium channels in cell membranes. Nifedipine and nimodipine, two channel blockers, may function by actually plugging the calcium channel of the cell membrane.

On the other hand, verapamil and diltiazem interact with the open calcium channel.

Wayne State scientists and others have proposed and demonstrated that tumor metastasis, or spread, is enhanced by tumor cells interacting with blood platelets. Agents which block or prevent tumor cell-platelet interaction and aggregation have antimetastatic effects.

Agents which have been investigated function by reducing platelet cells in the blood or by inhibiting platelet aggregation. The Wayne State team has investigated the antimetastatic effects of nimodipine in a number of different systems and has demonstrated that administration

Continued on next page

"Your urine test looks good, but we'll be grading on a curve."

DUIL
ALCOHOL
BREATH
ANALYZERS

$3000 per month
potential
4 hours per week

State of the art computerized unit of the highest quality, no selling involved, no overhead, no competition, excellent tax shelter. Limited number of distributorships available.

CALL
(517) 483-9079
or
(313) 270-2067

Prepare For:
- TOEFL
- MSKP
- NATIONAL MEDICAL BDS
- VQE
- ECFMG
- FLEX
- DENTAL BDS
- PODIATRY BDS
- NURSING BDS

- Voluminous home study notes on all areas of basic science.
- Teaching tests accompanied by comprehensive teaching tapes to be used at any of our tape centers.
- Materials constantly updated.
- Over 40 years of experience and success in the field of test preparation.

Stanley H. KAPLAN
EDUCATIONAL CENTER

For information Please Call:
Ann Arbor (313) 662-3149
Detroit (313) 569-5320
E. Lansing (517) 332-2539
Centers in More than 115 Major U.S. Cities, Puerto Rico and Toronto, Canada

of nimodipine to mice will significantly reduce metastasis.

Brain surgery

"Band Aid" brain surgery for certain types of brain tumors is now being offered at The University of Michigan Hospitals, one of only two medical centers in the United States offering the treatment originally developed in Sweden.

Neurosurgeon James A. Taren, MD, who does the procedure at U-M Hospitals, says he believes "it will prove to be not only safer but also more effective than current therapy for some craniopharyngiomas and other tumors deep within the brain that may form fluid-filled cysts."

The procedure uses an accurate method of locating brain tumors, called stereotaxy, and an injection of radioactive phosphorous. Only a very small hole needs to be drilled through the patient's skull, greatly reducing the risk to the patient and speeding recovery.

"The patients are calling it 'Band Aid' surgery," says Doctor Taren.

He learned the procedure on a sabbatical leave at the Karolinska Institute in Stockholm, Sweden, from Erik-Olof Backlund, MD, PhD, who has been developing stereotaxic treatments for a decade, using radioactive yttrium-90. Doctor Taren has assembled the specialized equipment and the team to offer the procedure at U-M Hospitals.

Liver cancer

Tiny spheres of starch play a big role in an experimental treatment for liver cancer underway at The University of Michigan Hospitals and Medical School.

Microscopic particles of starch in a salt-water solution are injected into the liver's blood supply along with a quick-acting chemotherapeutic drug. The microspheres are expected to retard circulation through the liver long enough to let the drug be more effective, explains William Ensminger, MD, U-M oncologist (cancer specialist) and director of the study.

A small medication pump, implanted under the skin of the patient's abdomen, sends the sphere and drug mixture into the artery of the diseased liver.

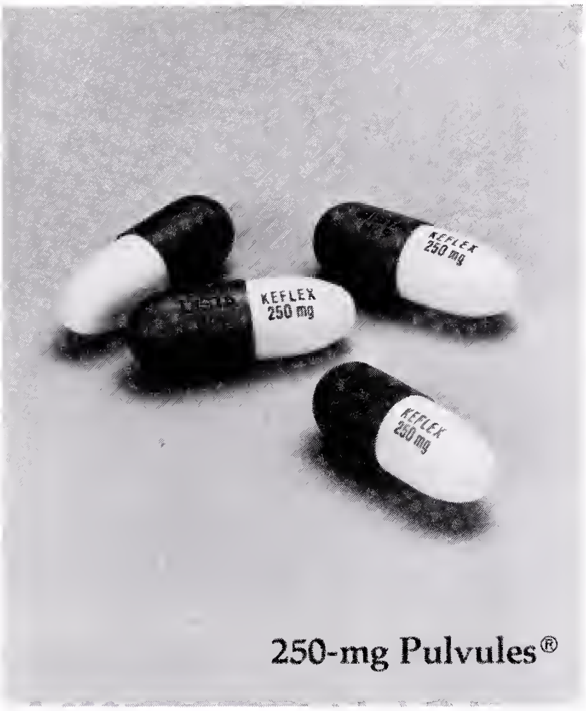
Tumors characteristically have very rich blood supplies, and the microspheres — each tiny ball is about the size of five red blood cells — tend to lodge more in the tumor than in the healthy part of the liver which can also get blood from another artery, Ensminger explains.

The microspheres temporarily clog the tumor's blood supply, holding the drug there instead of letting it wash on through the bloodstream. The starch particles are broken down by the body in about 20 minutes.

Ensminger and his colleagues at the U-M Hospitals have pioneered in the treatment of liver cancer with the implanted infusion pump — extending survival to as long as 25 months for patients with the disease which can be fatal in a matter of weeks.

Use of the microspheres may add further to the life expectancy of cancer patients, Ensminger believes.

easy to take



250-mg Pulvules®

Oral Suspension

250 mg/5 ml
100 and 200-ml
sizes

125 mg/5 ml
60, 100, and
200-ml sizes

Pediatric Drops

100 mg/ml
10-ml size

Keflex®
cephalexin

Additional information available
to the profession on request.

DISTA
000823

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

Nabil Z. Al-Hourani, MD — IM/CD
29049 Lorraine Blvd.
Warren 48093

Carlo P. Amazona, MD
3030 Carpenter
Hamtramck 48212

Kai Anderson — (student)
1496 W. Boston Blvd.
Detroit 48206

Julia Lynn Bills — (student)
1328 Washtenaw #8
Ann Arbor 48104

Robert H. Bleau — (student)
5400 Bingham
Dearborn 48126

Oded Boyman, MD — OBG
26802 Stanford Dr., W.
Southfield 48034

Carzadean B. Burke — (student)
201 E. Kirby #1206
Detroit 48202

Sanford Chen — (student)
1010 Catherine St. #501
Ann Arbor 48104

David I. Eisenstein — (student)
1335 Geddes #2
Ann Arbor 48104

Nancy Enos, MD — EM
404 Cloverly Rd.
Grosse Pte. Farms 48236

Gerard P. Farrar — (student)
21309 Erben
St. Clair Shores 48081

Richard Fessler — (student)
4 Hayden, E. Quad
Ann Arbor 48109

Karim M. Fram, MD
30646 W. Warren
Westland 48185

Gerald A. Friedman, MD — IM
360 Bronson Medical Ctr.
Kalamazoo 49007

Alan R. Gill — (student)
4 Hayden, E. Quad.
Ann Arbor 48109

K.W. Hamamdjian, MD — CRS/GS
5732 Aldingbrooke
West Bloomfield 48033

Ann L. Hammon — (student)
2602 Belmont St.
Hamtramck 48212

Eric Hanson, MD — GS/TS
6767 W. Outer Dr.
Detroit 48235

Vincent B. Ho — (student)
1351 Washtenaw
Ann Arbor 48104

Ray A. Hoag, MD — OBG
1022 Baldwin, SE
Grand Rapids 49506

Wade Hsu — (student)
3020 Bolgos Circle
Ann Arbor 48105

Christopher W. Hughes, MD — IM
24924 Norval
St. Clair Shores 48080

Susan N. Iovan, MD — AN
17267 Bentler
Detroit 48219

Salah Itani, MD — A
1917 A. Marian Drive
Trenton 48183

Russell D. Jelsema — (student)
24311 Calvin
Dearborn 48124

Takeshi Kataoka — (student)
1034 Island Dr. Ct. #101
Ann Arbor 48105

Dennis M. Keene, MD — AN
1308 Columbus
Bay City 48706

Lucia A. Kemennu — (student)
3020 Stockwell
Ann Arbor 48109

Andrew Kopystynsky, MD — GS
6351 Radnor St.
Detroit 48224

Margueritte H. Kuhn — (student)
324 E. Third #3
Royal Oak 48067

Paul B. Lattin, DO — TR
3990 John R
Detroit 48201

Bradley A. Levinson, MD — GS/CRS
1350 W. Bethune Ave.
Detroit 48202

Richard B. Loomis, Jr. — (student)
536 Elm St.
Ann Arbor 48109

Hugh L. Mackechnie, MD — A/IM
2799 W. Grand Blvd.
Detroit 48202

Carlos Marchena, MD — IM/NEP
455 S. Livernois A-22
Rochester 48063

James A. McGee — (student)
345 Hinsdale, E. Quad
Ann Arbor 48109

Wadad Y. McKay, MD — GP
29732 Spring Hill Drive
Southfield 48076

Margaret M. Moll — (student)
1015 E. Ann #1A
Ann Arbor 48104

IBM
From $4,880

The Professional Computer

MEDICAL OFFICE MANAGER

IBM/PC or XT Computers, with Management Software Options for:

- Patient Accounting
- Insurance Forms/Claims
- Appointment Scheduling
- Receivables & Payables
- Treatment/Lab Analysis
- Medical Records & Histories
- Productivity Summary
- Word-Text Processing
- Network Communications

IMPROVED:

Efficiency — Cash Flow — Profitability

— System Support, Leasing & Expansion Options —

Computer Systems 313/779-8700
26401 Harper — St. Clair Shores, MI 48081

Jefferson D. Morgan, MD — IM
2799 W. Grand Blvd.
Detroit 48202

Michael P. Mott — (student)
335 Catherine
Ann Arbor 48104

Ruth B. Nauts, MD
2010 Medford D-31
Ann Arbor 48104

Mohan Navarasala, MD — DR
21438 Dequindre
Warren 48091

Paul C. Nehra, MD — OBG
145 Rochdale Dr. C
Rochester 48063

Charles L. Nino — (student)
1316 Geddes Ave. #11
Ann Arbor 48104

Cheryl Pfefer — (student)
1520 S. University
Ann Arbor 48104

Lawrence B. Prussack, MD — OBG
20960 Potomac
Southfield 48076

Jack E. Rashkin, MD — IM
27000 Franklin Rd. #500
Southfield 48034

Peggy Richardson-Moore, MD — IM
22401 Foster Winter Dr.
Southfield 48075

William J. Saucier, MD — AN
3195 Long Rapids Rd.
Alpena 49707

Michael J. Schenden, MD — PS
755 W. Big Beaver
Troy 48084

Eric L. Shampaine — (student)
515 Lawrence #2
Ann Arbor 48104

Robert J. Sokol, MD — OBG
5200 Rector Ct.
Bloomfield Hills 48013

David Spear — (student)
1700 Prestwick
Grosse Pte. Woods 48236

William H. Straub, MD — R
4005 Orchard Dr.
Midland 48740

Daniel Stulberg — (student)
525 Walnut #6
Ann Arbor 48104

James F. Sullivan — (student)
1928 Geddes
Ann Arbor 48104

K.G. Surendran-Nair, MD — P
36213 Fredericksburg Rd.
Farmington Hills 48018

Lisa J. Tiziani — (student)
727 E. Kingsley #17
Ann Arbor 48104

Timothy J. Tobolic, MD — FP
8194 Byron Center Ave.
Byron Center 49315

Richard M. Tooker, MD — FP
2606 Raymond, SE
Grand Rapids 49507

Philip B. Vander Naald, MD — EM
560 W. Mitchell
Petoskey 49770

Donald W. Weaver, MD — GS
4201 St. Antoine Dept./Surg.
Detroit 48201

David F. Williams, MD — IM
15121 W. McNichols
Detroit 48235

Michael A. Wood — (student)
1316 Geddes #1
Ann Arbor 48104

TAKE A BREAK EACH WEDNESDAY

with **Health Care News**, the most accurate, reliable, and complete way to keep abreast of health care regulations, legislation, mergers, moves, negotiations, people, continuing education, and job opportunities. We give you the news you need to know **52 times a year for only $11. $20 for 2 years & a free coffee cup.**

Health Care News
Your FREE HCN Coffee Cup!

Health Care News
SERVING MICHIGAN'S HEALTH CARE PROFESSIONALS

Subscribe now. Limited time only.

☐ Payment Enclosed Firm Name (if applicable)________________
☐ New Name ________________
☐ Renewal Address ________________
☐ Bill me— $1.50 additional City/State/Zip ________________
☐ Bill firm—$1.50 additional Interbank #________________ Exp. Date ________
☐ Visa ☐ Mastercard Signature________________
Drivers License Number ________________

5440 Cass Avenue • Detroit, Michigan 48202 • (Phone (313) 831-3323
Telephone Orders Accepted

By Sheri W. Greenhoe

Owosso Memorial Hospital recently honored three physicians for their years of service: **George W. Bennett, MD,** Elsie, for 50 years of medical practice; **John G. Lyons, DO,** Owosso, also honored for 50 years of practice; and **John MacGregor, MD,** Owosso, for 30 years of medical practice. ... **Larry Braak, MD,** Marquette, and his wife Nancy are currently participating in the Ministry of Money Third World Pilgrimage, which will take them to India, Africa, Thailand and Hong Kong. The Braaks will help feed, clothe and bathe the people there, and hope to "raise their consciousness" and re-examine this society's attitude toward money. ... **D'Anne Kleinsmith, MD,** Detroit dermatologist, is a monthly host on "Ask the Doctor," a weekly call-in show on WXYZ radio. ... New Assistant Dean of the MSU College of Human Medicine's Lansing community campus is **Reynard Bouknight, MD, PhD,** East Lansing. ... **Myron M. LaBan, MD,** Bloomfield Hills, received the Richard and Hinda Rosenthal Award in Physical Medicine and Rehabilitation at the American Academy of Physical Medicine and Rehabilitation's annual meeting recently. Doctor LaBan is the first person ever to receive the award, which honors his research into the diagnosis and treatment of low back pain. ... New president of the Jackson County Medical Society is **John F. Stageman, MD.** Vice president is **Wayne Bare, MD.** New executive director of that society is **Richard L. Ambs**. ... **Nancy Crandall**, Muskegon, president-elect of the MSMS Auxiliary, was recently named one of two new community relations coordinators for Hackley Hospital. ... **Harry A. Towsley, MD**, Ann Arbor, was one of three people recently named honorary members of that city's Kiwanis Club. The membership honors Doctor Towsley's longstanding service and fundraising activity in Ann Arbor. ... New board members of the Michigan Association of the Professions are **Richard Gascoigne, MD**, Adrian; **Winifred Oyen, MD,** Freeland; and **Louis Zako, MD,** Dearborn Heights ... **Michael Klein, MD,** Grosse Pointe Park, is new director of surgical medicine and associate professor of surgery at WSU School of Medicine. ... **Clara Raven, MD**, Grosse Pointe Park, was awarded the Elizabeth Blackwell medal by the American Medical Women's Association. It is awarded annually, and this year honors Doctor Raven's research on SIDS. ... **C. Mark Vasu, MD**, Grand Rapids, is a member of the Bequests and Endowments Committee of the American College of Cardiology. ... **Alfred B. Swanson, MD**, Grand Rapids recently delivered the John S. Latta Centennial Lecture at the University of Nebraska, and organized and chaired a hand surgery review course, and a hand implant surgery course, both in Grand Rapids. He has been elected president of the International Federation of Societies for Surgery of the Hand, which is made up of 30 national and regional societies from 79 countries. In addition, Doctor Swanson has lectured and demonstrated in Saudi Arabia, Egypt, Lebanon, England, Scotland, Austria, Canada, Russia and throughout the US in the last several months. ... **Douglass A. Haddock, MD**, Kalamazoo, was elected to the Board of Directors of the Council of Medical Specialty Societies at the group's annual meeting. He is a representative from the American Academy of Family Physicians, where he is currently vice president. Doctor Haddock also serves on the Board of Trustees of the Family Health Foundation of America. ... **William C. Montgomery, MD**, Detroit pediatrician, is new treasurer of the Council of Medical Specialty Societies. He has served on the CMSS Board of Directors for two years. ... New Barry County Medical Society officers are: **Eldon E. Cassell, MD**, president; **Michael K. McAlvey, MD**, president-elect; and **Paul T. DeWitt, Jr., MD**, secretary-treasurer.

Maurice Chapin, MD, right, Millington family physician, received a $5,000 check Nov. 23 from MSMS President-elect Louis R. Zako, MD. The check was part of the MSMS Plessner Award, which honors the MD who most exemplifies the good qualities of the rural Michigan family physician.

"A New Dimension in the Treatment of Alcoholism, Drug Dependency and Food Addiction"

NAPLES RESEARCH
& COUNSELING CENTER

Offering Multi-Program Approaches for Individuals and Families Suffering from
- Alcoholism
- Drug Dependencies
- Life Adjustment
- Food Addiction

Our professionally staffed JCAH approved chemical dependency program is covered by CHAMPUS and most other group health care plans.

CALL US TODAY for a Confidential Evaluation or Intervention Assistance
(813) 775-4500

9001 Tamiami Trail East, Naples, Florida 33962
An Affiliate of The Palm Beach Institute Family of Programs, Incorporated

Of possibilities and potential

By Carol Batdorf

Working on a long range planning committee is a dream.

That's what you do — dream! We use words like possible, could and potential.

To be good at long range planning, however, one must be familiar enough with reality to know that all our dreams won't come true. If they did, the state of Michigan would look to MSMS/A as the leading women's forum on medicine and the doctor's family. We would spearhead awe-inspiring health projects that in turn reflect a positive image of the physician in the community. The policy-making board would coordinate an army of well-trained state leadership. We would use all our human and material resources wisely.

Many of these dreams are a reality. We see it every time the auxiliary meets or we receive the "Auxilium," the legislative materials or our other auxiliary periodicals. What we are today is the result of a long history of ambitious dreams and plans.

This summer the long range planning committee conducted a review of the entire organization using a resource person and brainstorming/prioritizing techniques. Three goals were identified and assignments were made for further study. One of the goals, to study the internal functions of the organization, resulted in a recommendation to the board to form a special committee. The committee will be chaired by Nancy Crandall, Muskegon MSMS/A president-elect. They plan to begin work after the first of the year. The other two goals will deal with marketing membership and leadership training. We work on a three-to-five year plan.

I'm sure every member could fill in the "I wish the Auxiliary would ____________" and we wish you would. If you share your ideas with us we will listen. As long as we continue to dream and plan we can count on a strong, effective future.

Mrs. Batdorf is long range planning chairman for MSMS/A. She lives in Grand Blanc.

References:
1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angir pectoris. *Am Heart J* 104:672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302:1269-1273, June 5, 198

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated fo management of vasospastic angina confirmed by any of the following criteria 1) classical pat of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm voked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those pati who have had angiography, the presence of significant fixed obstructive disease is not incompa with the diagnosis of vasospastic angina, provided that the above criteria are satisfied PROCAF may also be used where the clinical presentation suggests a possible vasospastic componen where vasospasm has not been confirmed, e g , where pain has a variable threshold on exertio in unstable angina where electrocardiographic findings are compatible with intermittent v spasm, or when angina is refractory to nitrates and or adequate doses of beta blockers

II. **Chronic Stable Angina (Classical Effort-Associated Angina):** PROCARDIA is indicate the management of chronic stable angina (effort-associated angina) without evidence of vasosp in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nit or who cannot tolerate those agents

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in contr trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolera but confirmation of sustained effectiveness and evaluation of long-term safety in those patient incomplete

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA beta blocking agents may be beneficial in patients with chronic stable angina, but available mation is not sufficient to predict with confidence the effects of concurrent treatment, especia patients with compromised left ventricular function or cardiac conduction abnormalities Whe troducing such concomitant therapy, care must be taken to monitor blood pressure closely severe hypotension can occur from the combined effects of the drugs (See Warnings)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effe PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorl erated hypotension These responses have usually occurred during initial titration or at the ti subsequent upward dosage adjustment, and may be more likely in patients on concomitant blockers

Severe hypotension and or increased fluid volume requirements have been reported in pa receiving PROCARDIA together with a beta blocking agent who underwent coronary artery by surgery using high dose fentanyl anesthesia The interaction with high dose fentanyl appears due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occu PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other na analgesics cannot be ruled out In PROCARDIA treated patients where surgery using high fentanyl anesthesia is contemplated, the physician should be aware of these potential problem if the patient's condition permits, sufficient time (at least 36 hours) should be allowe PROCARDIA to be washed out of the body prior to surgery

Increased Angina: Occasional patients have developed well documented increased frequenc ration or severity of angina on starting PROCARDIA or at the time of dosage increases The anism of this response is not established but could result from decreased coronary perf associated with decreased diastolic pressure with increased heart rate or from increased de resulting from increased heart rate alone

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a drawal syndrome with increased angina, probably related to increased sensitivity to cate amines Initiation of PROCARDIA treatment will not prevent this occurrence and might be exp to exacerbate it by provoking reflex catecholamine release There have been occasional repo increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation It is impo to taper beta blockers if possible, rather than stopping them abruptly before begi PROCARDIA

Congestive Heart Failure: Rarely patients usually receiving a beta blocker, have developed failure after beginning PROCARDIA Patients with tight aortic stenosis may be at greater ri such an event

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vas resistance, careful monitoring of blood pressure during the initial administration and tit of PROCARDIA is suggested Close observation is especially recommended for patients a taking medications that are known to lower blood pressure (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial dilation and not due to left ventricular dysfunction, occurs in about one in ten patients treate PROCARDIA This edema occurs primarily in the lower extremities and usually responds to d therapy With patients whose angina is complicated by congestive heart failure care should be to differentiate this peripheral edema from the effects of increasing left ventricular dysfuncti

Drug interactions: Beta-adrenergic blocking agents. (See Indications and Warnings) Exp in over 1400 patients in a non-comparative clinical trial has shown that concomitant adminis of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occ literature reports suggesting that the combination may increase the likelihood of congestiv failure, severe hypotension or exacerbation of angina

Long-acting nitrates PROCARDIA may be safely co-administered with nitrates, but ther been no controlled studies to evaluate the antianginal effectiveness of this combination

Digitalis Administration of PROCARDIA with digoxin increased digoxin levels in nine of normal volunteers The average increase was 45%. Another investigator found no increas goxin levels in thirteen patients with coronary artery disease In an uncontrolled study of o hundred patients with congestive heart failure during which digoxin blood levels were not ured, digitalis toxicity was not observed Since there have been isolated reports of patien elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, ing, and discontinuing PROCARDIA to avoid possible over- or under-digitalization

Carcinogenesis, mutagenesis, impairment of fertility When given to rats prior to matin dipine caused reduced fertility at a dose approximately 30 times the maximum recommen man dose

Pregnancy Category C Please see full prescribing information with reference to teratogen rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys

ADVERSE REACTIONS: The most common adverse events include dizziness or light-heade peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% tients, transient hypotension in about 5%, palpitation in about 2% and syncope in about Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant ginal medication Additionally, the following have been reported muscle cramps, nervou dyspnea, nasal and chest congestion, diarrhea constipation, inflammation, joint stiffness ness, sleep disturbances, blurred vision, difficulties in balance, dermatitis pruritus urtic ver, sweating, chills, and sexual difficulties Very rarely, introduction of PROCARDIA thera associated with an increase in anginal pain, possibly due to associated hypotension

In addition, more serious adverse events were observed, not readily distinguishable from ural history of the disease in these patients It remains possible however, that some or these events were drug related Myocardial infarction occurred in about 4% of patients and tive heart failure or pulmonary edema in about 2% Ventricular arrhythmias or conduction ances each occurred in fewer than 0 5% of patients

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkalin phatase, CPK, LDH, SGOT, and SGPT have been noted and a single incident of significar vated transaminases and alkaline phosphatase was seen in a patient with a history of gall disease after about eleven months of nifedipine therapy The relationship to PROCARDIA th uncertain These laboratory abnormalities have rarely been associated with clinical sym Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensiv literature

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nif PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (ND 2600-72), and unit dose (10x10) (NDC 0069-2600-41) The capsules should be protecte light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in t ufacturer's original container

More detailed professional information available on request © 1982, Pf

Pfizer **LABORATORIES DIVISION**
PFIZER INC

"I can do things that I couldn't do for 3 yrs. including joining the human race again."

Quotes from an unsolicited etter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all espond to the same degree.

1983, Pfizer Inc.

"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).

for the varied faces of angina

PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

rocardia is indicated for the management of:
) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible asospastic component.
3) Chronic stable angina without evidence of vasospasm in atients who remain symptomatic despite adequate doses of eta blockers and/or nitrates or who cannot tolerate these gents. In chronic stable angina (effort-associated angina) ROCARDIA has been effective in controlled trials of up to ight weeks' duration in reducing angina frequency and ncreasing exercise tolerance, but confirmation of sustained ffectiveness and evaluation of long-term safety in these atients are incomplete.

Please see PROCARDIA *brief summary on adjoining page.*

Motrin®
ibuprofen, Upjohn
600 mg Tablets

MOTRIN
600 mg

More convenient for your patients.

Upjohn

©1984 The Upjohn Company

The Upjohn Company • Kalamazoo, Michigan 49001 USA

J-4044 January 1984

MSMS, MSMS/A, AMA, and medical assistants

Feb. 4-5, 1984 — "Through the Looking Glass," American Association of Medical Assistants, Michigan State Society, Mid-Winter Seminar, Amway Grand Plaza, Grand Rapids, contact: Caroline Rich, MSMS headquarters.

Feb. 23-25, 1984 — AMA 1984 National Leadership Conference, "Bold New Directions," Downtown Marriott Hotel, Chicago, contact: AMA, 535 N. Dearborn St., Chicago 60610 (312) 751-6000.

March 7, 1984 — MSMS Board of Directors meeting, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

March 28-29, 1984 — Maternal Health Conference, Hyatt Regency Dearborn, contact: Katie Brewbaker, MSMS headquarters.

April 12, 1984 — Sports Medicine Conference, Long's of Lansing, contact: Mert Scholten, MSMS headquarters.

April 26-29, 1984 — Annual State Convention, American Association of Medical Assistants, Inc., Michigan State Society, Lansing Hilton Inn, contact: Caroline Rich, MSMS headquarters.

May 4-6, 1984 — MSMS House of Delegates Meeting, Amway Grand Plaza Hotel, Grand Rapids, contact Warren Tryloff, MSMS headquarters.

July 26-29, 1984 — Midsummer Meeting, MSMS Board of Directors, Deer Lake, Boyne Mountain, contact: Warren F. Tryloff, MSMS headquarters.

Sept. 19, 1984 — MSMS Board of Directors meeting, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Nov. 21, 1984 — MSMS Board of Directors meeting, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Other meetings

April 2, 1984 — 63rd Annual Beaumont Lecture, John S. Najarian, MD, Minnesota, Speaker. Contact: Wayne County Medical Society headquarters.

June 7-9, 1984 — American Hospital Association 7th Annual Trustee Forum, Chicago. For program information, contact: B. Olsen, AHA, (312) 280-6301; for registration, contact: Division of Education (312) 280-6083.

June 14-15, 1984 — Michigan Chapter, American College of Surgeons Annual Meeting: Day 1, Resident Surgeons Day Competition; Day 2, Scientific Meetings. Grand Traverse Resort, Grand Traverse Village, contact: Viola M. Heins (517) 337-1351.

PRE-REGISTER NOW

MEDICLINICS

POSTGRADUATE MEDICAL REFRESHER COURSE

FORT LAUDERDALE, FLORIDA

MARCH 5 — MARCH 16, 1984

TRANSPLANT SURGERY GENERAL SURGERY INFECTIOUS DISEASES DERMATOLOGY ATHLETIC MEDICINE GASTROENTEROLOGY

RADIOLOGY ORTHOPEDIC SURGERY ONCOLOGY NUCLEAR RADIOLOGY LEGAL PROBLEMS GYNECOLOGY

CARDIAC SURGERY GENETICS CARDIOLOGY GERIATRICS HEMATOLOGY EMERGENCY MEDICINE

50 CATEGORY 1 CREDIT HOURS

LIMITED 25 CREDIT ONE WEEK COURSE AVAILABLE

"This program has been reviewed and is acceptable for 50 Prescribed Hours by the American Academy of Family Physicians. As an organization accredited for continuing medical education, the Florida Academy of Family Physicians designates this program as meeting the criteria for 50 credit hours in Category I of the Physician's Recognition Award of the American Medical Association. This program also is acceptable for 50 Mandatory hours by the Florida Medical Association."

PRE-REGISTRATION — $400

(UNTIL FEBRUARY 15, 1984)

FOR INFORMATION CONTACT:

MEDICLINICS

133 Peninsula Road
Medicine Lake, Minnesota 55441
(612) 544-0039

2917 South Ocean Blvd., Suite 905
Highland Beach, Florida 33431
(305) 272-8973

EXCELLENT FACULTY, FINEST HOTELS PEAK OF WINTER SEASON

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, (517) 337-1351.

Date: February 11, 1984, February Seminar, Michigan Society of Pathologists — "Quality Control in the Clinical Laboratory." Location: Henry Ford Hospital, Detroit. **Sponsor:** Michigan Society of Pathologists in cooperation with the Great Lakes Regional Quality Control Program. **Contact:** Willys F. Mueller, MD, Dept. of Pathology, Hurley Hospital, Flint 48503. **Approved for:** 3 hours of Category I Credit.

Date: February 12-17, 1984, Emergencies in Medicine. Location: Boyne Highlands, Harbor Springs. **Sponsors:** Michigan Committee on Trauma, ACS; WSU School of Medicine; Michigan Society of Critical Care Medicine. **Contact:** Theresa Sokol, WSU Department of Surgery, 6-C UHC, 4201 St. Antoine, Detroit 48201 (313) 577-5009. **Approved for:** 25 hours of Category I Credit.

Date: March 17-24, 1984, Aspen Conference on Emergencies in Medicine. Location: Aspen Conference Center, Continental Inn, Aspen, Colorado. **Sponsor:** Michigan Committee on Trauma, ACS; Michigan Society of Critical Care Medicine; Wayne State University School of Medicine. **Contact:** Theresa Sokol, WSU Department of Surgery, 4201 St. Antoine, Detroit 48201 (313) 577-5009. **Approved for:** 30 hours of Category I Credit.

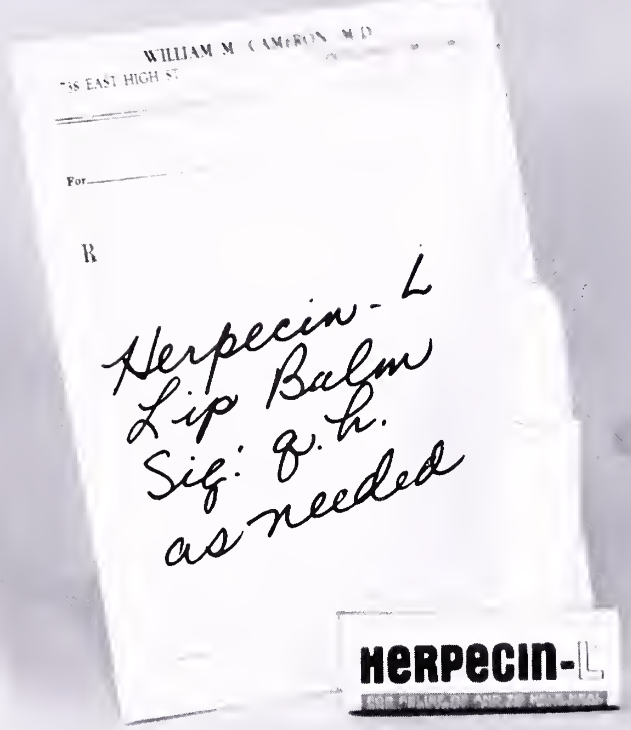
Date: April 9-11, 1984, Hemodynamic Monitoring. Location: Towsley Center, Ann Arbor. **Sponsor:** U-M Dept. of Pathology and Office of Continuing Medical Education. **Contact:** Office of CME, Towsley Center, Box 057, U-M Medical School, Ann Arbor, 48109, (313) 763-1400. **Approved for:** 14.5 hours of Category I Credit.

Date: April 13-15, 1984, Tutorial on Myofascial Release Technique. Location: Kellogg Center for Continuing Education, MSU, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine. **For:** DOs and MDs. **Contact:** Sandy Kilbourn, A306 E. Fee, MSU-COM, East Lansing, 48824. **Approved for:** 32 hours of Category I Credit.

Date: April 25-26, 1984, What's New and Practical in Critical Care. Location: Michigan Inn, Southfield. **Sponsors:** Michigan Committee on Trauma, ACS; WSU School of Medicine; Michigan Society of Critical Care Medicine. **Contact:** Theresa School, WSU Department of Surgery, 6-C UHC, 4201 St. Antoine, Detroit 48201 (313) 577-5009. **Approved for:** 12 hours of Category I Credit.

Date: May 5-9, 1984, Advanced Muscle Energy Tutorial (below diaphragm). Location: Kellogg Center for Continuing Education, East Lansing. **Sponsors:** Michigan State University College of Osteopathic Medicine and College of Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

Date: June 11-15, 1984, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsors:** MSU Colleges of Osteopathic Medicine and Human Medicine, and the North American Academy of Manipulative Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.



Dx: recurrent herpes labialis

"Herpecin-L Lip Balm is **the treatment of choice** for peri-oral *herpes.*" GP, New York

"In the management of *herpes labialis,* Herpecin-L is a **conservative approach with low risk / high benefit.**" Derm., Miami

"Staff and patients find Herpecin-L remarkably **effective.**" Derm., New Orleans

OTC. See *P.D.R.* for information.
For trade packages to make your own clinical evaluation, write:
CAMPBELL LABORATORIES INC.
P.O. Box 812-M, FDR, NY, NY 10150

In Michigan, "HERPECIN-L" Cold Sore Lip Balm is available at all *Muir, Perry, Revco* and *Sentry Drug Stores* and other select pharmacies.

LABORATORY OF CLINICAL MEDICINE

MID-MICHIGAN REFERENCE LABORATORY, II, Inc.
(517) 372-8180

1322 E. Michigan Ave.
Suite 102
Lansing, Michigan 48912

930 E. Mt. Hope Ave.
Lansing, Michigan 48910

2909 E. Grand River Ave.
Suite 104
Lansing, Michigan 48912

W. E. Maldonado, M.D.
Director

Robert B. Foy, Ph.D.
Chief Executive Officer

Ann E. Chernys, M.D.
John W. Dyke, Ph.D.
Dennis E. Freer, Ph.D.
John J. Gillespie, M.D.
Ronald N. Horowitz, M.D.
John R. Kateley, Ph.D.
John J. Lyday, M.D.

Joseph R. Melvin, Ph.D.
Sandra K. Shirley, M.D.
Laurence R. Simson, Jr., M.D.
Susan M. Strate, M.D.
Carolyn M. Texera, M.D.
Irene K. Trombley, M.D.
Susan C. Weisz, Ph.D.

REFERENCE LABORATORY FOR SPECIALIZED PROCEDURES
Specimen Pickup and Delivery of Test Results Daily
Assignment is accepted from Medicare, Medicaid, Blue Shield and all other insurance carriers.

To Learn the Latest in the Recognition, Diagnosis & Treatment of Athletic Injuries

Plan Now to Attend the

1984 MSMS

CONFERENCE ON SPORTS MEDICINE

to be held

Thursday, April 12

at

LONG'S CONVENTION CENTER

LANSING

Earn Category I CME Credit; hear expert guest clinicians;
meet fellow physicians, coaches and trainers.

Otto O. Beck, MD
Venice, Florida
Otto O. Beck, MD, formerly of Birmingham, died September 29. He was 89. Doctor Beck served as MSMS president in 1951-52, and was a former chairman of the MSMS Council (Board of Directors). His greatest pleasure, according to his family, was his chairmanship of the committee to develop the Beaumont Memorial on Mackinac Island. Doctor Beck was a 1920 graduate of Northwestern University medical school. He had been affiliated with William Beaumont and St. Joseph Mercy hospitals, and retired in 1970.

Sidney L. Berman, MD
Huntington Woods
Sidney L. Berman, MD, Huntington Woods, died September 9 at the age of 80. He was founder of the Detroit Industrial Clinic. A 1925 graduate of the University of Syracuse School of Medicine, Doctor Berman taught proctology at Wayne State University Medical School and Harper Hospital. He had been a chief medical officer in the Navy during World War II, and retired from medicine in 1970.

Martin F. Bruton, MD
Sun City, Arizona
Martin F. Bruton, MD, formerly of Grosse Pointe Farms, died September 9. He was 77. Doctor Bruton had been medical director of Chrysler Corporation for 16 years and retired from that position in 1972. Prior to his work with Chrysler, Doctor Bruton was in private practice in the Saginaw area. He was a 1930 graduate of the Wayne State University School of Medicine, a past president of the Michigan Industrial Medicine Association, and a trustee of the Detroit Rehabilitation Institute.

William A. Corcoran, MD
Port Washington, Wisconsin
William A. Corcoran, MD, formerly of Ishpeming, died November 4. He was 90. Doctor Corcoran had been a family physician and city health official in that area for more than 50 years. He was active in civic groups, and had been affiliated with Bell Memorial and St. Mary's hospitals. Doctor Corcoran earned his MD degree in 1923 from the University of Michigan Medical School, and served in the US Navy during World War I.

Alphonse R. Deresz, MD
Detroit
Alphonse R. Deresz, MD, Detroit GP, died November 11 at the age of 68. Doctor Deresz was a 1941 graduate of the University of Michigan Medical School, and had been affiliated with Holy Cross Hospital. He retired from private practice several years ago after suffering a stroke. He was a World War II medical corps veteran, and was a member of Theta Kappa Psi medical fraternity.

Stephen Fairbanks, MD
Albion
Stephen Fairbanks, MD, Albion, died September 26. He was 82. Doctor Fairbanks began his career in medicine in Luther, where he practiced with his physician father. He followed that with two years as commanding officer of the station hospital at Camp Custer in Battle Creek. Doctor Fairbanks moved his practice to Albion, where he concentrated on ophthalmology and became affiliated with Sheldon Memorial Hospital. He earned his MD degree in 1926 from U-M, and retired from practice in 1968.

Paul M. Fuller, MD
Mill Valley, California
Paul M. Fuller, MD, formerly of Kalamazoo, died September 30 at the age of 82. Doctor Fuller earned his MD degree from Wayne State University School of Medicine, then entered the Navy as a surgeon. He resigned from the Navy to open a private practice in Kalamazoo, but returned to the military during WWII where he earned the rank of Commander in the African Theatre. His hospital unit was presented the Meritorious Service Unit Award for superior performance under his command. Doctor Fuller was active in community theatre and was a poet and sculptor.

Frank W. Garber, MD
Muskegon
Frank W. Garber, MD, Muskegon, died September 15 at age 87. Doctor Garber was one of several generations of Garbers who practiced medicine in that community, serving patients personally for more than 50 years. In 1922 he graduated from Johns Hopkins School of Medicine. Doctor Garber specialized in surgery, and was affiliated with Hackley Hospital, where his father had been chief of staff, and with Mercy Hospital. Doctor Garber's son, Frank W. Garber, III, MD, is a Muskegon orthopedic surgeon.

Robert H. Harper, MD
Flint
Robert H. Harper, MD, Flint, died October 22. He was 75. Doctor Harper practiced medicine in the Flint area for 48 years, and was once medical director at Buick Motor Division. Doctor Harper also served as chairman of the Blood Program Committee of the local American Red Cross chapter. He was a 1934 University of Michigan Medical School graduate, and served an internship at Hurley Hospital.

Donald J. Kennedy, MD
Clearwater, Florida
Donald J. Kennedy, MD, formerly of Detroit, died October 29 at the age of 76. Doctor Kennedy had been affiliated with several Detroit area hospitals during his long Michigan career. He retired to Florida last year. Doctor Kennedy served as a lieutenant colonel in the Army Medical Corps during World War II.

William B. Kerr, MD
Saginaw
William B. Kerr, MD, Saginaw, died November 7. He was 76. Doctor Kerr, a native of Scotland, practiced in Saginaw for more than 40 years. He earned his medical degree in 1940 from Wayne State University School of Medicine, and had been affiliated with Saginaw General, St. Luke's and St. Mary's hospitals. At one time Doctor Kerr served as president of the American Association of General Practitioners (now AAFP). He was a World War II veteran.

Edward W. Laboe, MD
Monroe
Edward W. Laboe, MD, former Monroe County Medical Society president, died October 1. He was 80. Doctor Laboe was former director of the Michigan State Sanitarium in Howell. He earned his medical degree in 1929 from the U-M Medical School, and interned and took his residency at U-M Hospital. When a merger was initiated between Mercy and Memorial hospitals, Doctor Laboe served as chairman of the board of directors of the facilities. At one time he was acting director of the Monroe County Health Department.

Adolph W. Lowe, MD
Pompano Beach, Florida
Adolph W. Lowe, MD, formerly of Detroit, died September 7 at the age of 75. Doctor Lowe was a 1934 graduate of Wayne State University School of Medicine, and was a general practitioner. He emphasized internal medicine and psychiatry in his practice. He was a former president of the Maimonides Medical Society.

Continued on page 45

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

1st FOR PROFESSIONAL PROTECTION EXCLUSIVELY

YOUR FIRST STEP TO FIRST QUALITY PROTECTION
CONTACT FIELD REPRESENTATIVES

Eastern Office
RICHARD K. WIND, JOHN K. GALLOWAY, THOMAS A. WEISMAN,
WAYNE M. BACKUS and MARK A. TISDEL
6785 Telegraph Road, Suite 350, Birmingham, Michigan 48010
(313) 647-6640

Western Office
GEORGE J. HAWORTH
2600 Five Mile Road, NE, Suite 101
Grand Rapids, Michigan 49505
(616) 361-0863

How to reduce your accounts receivable without lifting a finger.

If your accounts receivable look like the National Debt, don't blame the economy entirely. Your billing system might be part of the problem. Late statements mean late collections. Error-prone or ambiguous statements collect complaints instead of cash.

The Control-o-fax Statement Service eliminates these problems. This service gets your billing out on time every time. And each statement is the exact "picture" copy of your ledger card.

Our Control-o-fax Statement Service clients have reduced their accounts receivable significantly without lifting a finger. Call for full details.

Detroit Area:
Creative Systems, Inc.
19675 W. Ten Mile Rd.
Southfield, MI 48075
(313) 352-9425

Control-o-fax®
STATEMENT SERVICE

Outstate Michigan:
Reed Office Systems, Inc.
2121 Three Mile Road, N.W.
Grand Rapids, MI 49504
(616) 784-4755
LANSING 482-0200 FLINT 238-7447
TRAVERSE CITY 941-7771
SAGINAW 752-8802

The rate for each classified advertisement in *Michigan Medicine* is 20¢ per word, with a minimum charge of $10.00. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

Positions Open

FAMILY PHYSICIAN — Needed immediately to join a well-established family practice in thoroughly equipped office. Excellent financial opportunity in Alpena, Michigan, a friendly town on beautiful Lake Huron. 135-bed hospital is completing expansion and renovation project. Contact James Mazrum, JD, (517) 356-3444, 109 Chisholm St., Alpena, Michigan 49707.

SUNNY SOUTHERN ARIZONA, ideal climate, fast-growing community near major recreation areas. Excellent opportunity for family physician to associate in large, well-established practice, superb new facilities. Contact Thad J. Earl, MD, 302 El Camino Real, Suite 4, Sierra Vista, Arizona 85635. (602) 458-8110 or (602) 458-7325.

ORTHOPEDIC SURGEONS WANTED — Stable, highly respected organization which limits its activities to evaluation medicine is in need of American Board Certified orthopedic surgeons, on a full or part-time basis, in southeast Michigan (Detroit, Flint, Bloomfield). This is an excellent opportunity for those orthopedic surgeons who wish to eliminate the day-to-day problems of treatment practice, or for those who seek part-time forensic work as a supplement to treatment income. Work schedules revolve around individual work load requirements and physician-determined availability. Please forward Curriculum Vitae to J.C. Day, MD, 14295 East Seven Mile Road, Detroit, Michigan 48205 or call collect (313) 527-4620.

FAMILY PRACTICE (BATTLE CREEK) — Two man family practice seeking one or two physicians doing over $400,000 gross yearly. Serving area of 100,000 with three open hospitals. Salary first year. Full partner after one year. Health insurance, disability insurance, pension and profit sharing plans, six weeks vacation. Inquire to Cinde VanDusen, Capital Avenue Medical, PC, 719 Capital Avenue SW, Battle Creek, MI 49015. Phone (616) 965-5188 (9am-5pm).

FULL TIME PHYSICIAN NEEDED for occupational and industrial health position. Send CV and/or resumé to 5916 Oakland Drive, Kalamazoo, MI 49002.

GRAND RAPIDS, MICHIGAN — MEDICAL CONSULTANTS, INC. is seeking Board Certified Orthopedic Surgeon to perform independent orthopedic examinations and be willing to testify in accordance with these findings should legal proceedings arise. There will be no treatment of patients involved with this position. Excellent compensation, flexible hours, insurance provided, vacation and special meetings allowance. Submit CV to: John Rupke, MD, Towers Medical Building, Suite 340, 21 Michigan NE, Grand Rapids, Michigan 49503 (616) 458-2841 (office); (616) 949-2138 (home).

WANTED: ANESTHESIOLOGIST FOR 7 (seven) man group (PC) of Board eligible or certified anesthesiologists employing 8 (eight) CRNA's. We practice in 2 (two) hospitals with a total capacity of 600-700 beds. All specialty modalities are represented in the community. No routine obstetric coverage. LOCATION — Muskegon, Michigan, situated on Lake Michigan and several inland lakes providing ample opportunity for all nautical, pictorial pursuits and other outdoor activities. If interested, please write to: A.M. Chiasson, MD, 1060 W. Norton Ave., Muskegon, MI 49441.

GENERAL INTERNISTS AND FAMILY PRACTITIONERS interested in geriatric medicine will find an optimal practice setting in our Sun City, AZ healthcare centers. CIGNA Healthplan, Inc., one of the nation's largest prepaid health plans, offers an opportunity to practice medicine free of the business aspects. Night and weekend call is very light. Competitive salaries. Excellent benefits. Please respond to: Director, Professional Recruitment, PO Box 29030, Phoenix, AZ 85038 (602) 954-3506.

ENJOY THE NORTHWOODS! Need an aggressive, hardworking Internal Medicine Specialist and a Family Practice Specialist to join a brand new clinic in Eagle River, Wisconsin. Great income potential and outstanding fringe benefit packages available. For further information call collect (715) 842-3202, or write to Administrator, 2409 N. 13th, Wausau, Wisconsin 54401.

ANESTHESIOLOGIST: Board Certified or Eligible to join CRNA as Chief in a JCAH approved 129-bed hospital in Northern Michigan four-season vacationland. Excellent schools and quality of life. Live on Lake Huron or one of our large inland lakes and be only minutes from the Hospital. Financial arrangements open to discussion. Send c.v. to D. Spedding, Community Memorial Hospital, Box 419, Cheboygan, MI 49721.

PRIMARY CARE PHYSICIANS needed for multi-specialty clinic with family practice base. Need primary care general practice internists and general surgeons. Reply with CV to — Administrator, Redford Medical Center, 25210 Grand River, Detroit, MI 48240.

OB/GYN, ENT, Ophthalmologist, Urologist, Pediatrician in Virginia; excellent place to practice; coverage population of 40 to 50 thousand; minimum guarantee; excellent weather; sixty miles south of Richmond; near ocean. Send CV to Administrator, Greensville Memorial Hospital, 214 Weaver Avenue, Emporia, Virginia 23847 or call 804/348-2000.

EMERGENCY MEDICINE — Director and staff physicians sought for hospital emergency department in scenic western Michigan near Benton Harbor. Spectrum physicians are provided with a competitive income, professional liability insurance, CME tuition, ACLS, ATLS, and ACEP membership dues reimbursement. Moving allowance if relocation is necessary. For further details respond in confidence to: Mr. Jim Murphy, Spectrum Emergency Care, Inc., 999 Executive Parkway, St. Louis, MO 63141; 1-800-325-3982.

FAMILY PHYSICIAN: IMMEDIATE OPENING for a residency trained FPpreferring small-town life style and interested in "whole person medicine from the Christian perspective" in a new office in the small college town of Hillsdale in southern Michigan. Write or call: Frederick L. Bean, MD, Hillsdale Family Practice, 111 South Howell, Hillsdale, Michigan 49242, (517) 437-7307.

UROLOGIST NEEDED — to join extremely active one-man practice in the four-season vacationland of Northern Lower Michigan. Associate is necessary to share existing workload and to adequately cover our expanded service area. Salary guarantee and fringe benefit package available. If interested, send c.v. to David Spedding, Assistant VP, Community Memorial Hospital, Cheboygan, MI 49721.

SOUTHERN CALIFORNIA — We are seeking experienced specialists and general practitioners for our facilities in Los Angeles and Orange Counties. Located in close proximity to major teaching centers, we offer the opportunity of continued professional development and rewarding clinical practice in association with 350 full time physicians. Compensation and benefits are excellent including paid vacation, educational leave, sick leave, and retirement; insurances included are malpractice, life, disability, medical and dental. Send CV to: Director/Physician Recruitment, CIGNA Healthplans of California, 700 N. Brand Blvd., Suite 500, Glendale, CA 91203.

POSITIONS WITH THE STATE OF MICHIGAN — Currently taking applications for positions expected to be available in the future. Primarily interested in board certified or board eligible internists with cardiology background for office location in Southfield, Lansing, and Traverse City. An office is planned for Kalamazoo in mid-1983. Other backgrounds in medicine will be considered for the Kalamazoo office. Salary in high 50's with approximately 26% fringe benefits. An equal opportunity employer. All inquiries treated confidentially. For further details, please write: Disability Determination Service, P.O. Box 30011, Lansing, MI 48909, or call collect: Harry D. Nesmith, M.D., Chief Medical Consultant (517) 373-7830. In Michigan call toll free 1-800-292-2710.

FAMILY PHYSICIANS: Needed to locate in and provide medical care at satellite clinic in three northern Michigan resort communities within our service area. Salary guarantee, vacation, educational leave and fringes provided. Coverage assured and no initial investment required. Call or send current c.v. to: David H. Spedding, Community Memorial Hospital, Box 419, Cheboygan, MI 49721 (616) 627-1201.

Miscellaneous

MIDWEST PAIN SOCIETY 8TH ANNUAL SCIENTIFIC MEETING, "PRACTICAL MANAGEMENT OF COMMON PAIN SYNDROMES," March 16-17, 1984, Westin-Crown Center Hotel, Kansas City, MO. Guest Speaker: Jes Olesen, MD, Hellerup, Denmark. Contact Jan Johnston, Office of C.E., Univ. of Kansas Medical Center, Rainbow at Olathe, Kansas City, KS 66103. (913) 588-4480.

SPORTS MEDICINE: REHABILITATION OF THE INJURED ATHLETE, March 15-1984, Westin-Crown Center Hotel, Kansas City, MO. Guest Speakers: Barbara J. DeLateur, MD, Univ. of Washington-Seattle, and James H. McMaster, MD, Univ. of Pittsburgh. Contact Jan Johnston, Office of C.E., Univ. of Kansas Medical Center, Rainbow at Olathe, Kansas City, KS 66103. (913) 588-4480.

SAVE ON A CRUISE — Due to health conditions, SAVE $500.00 on two 8-day trips to Panama. Available dates January, February, March or April. 3 nights Panama City, 5 days — 4 nights cruising Panama Canal. For more information, call Sherman Lepard (formerly of Medical Arts Pharmacy) (616) 891-1336.

ACTIVE MEDICAL PRACTICE FOR SALE. Detroit area. Grossing $300,000. Call Commonwealth Group (313) 288-0022.

ACTIVE GENERAL PRACTICE FOR SALE in Detroit. Doctor relocating out of country. Sale price $22,400. Call Commonwealth Group (313) 288-0022.

FOR SALE — GENERAL PRACTICE, St. Clair Shores. Doctor retiring. Call Commonwealth Group (313) 288-0022.

WE HAVE QUALIFIED PURCHASERS looking to purchase Nursing Homes in Michigan. All inquiries confidential. Call Commonwealth Group (313) 288-0022.

PRACTICES WANTED. We have qualified purchasers looking to assume established MD, DO, and DDS practices in Metro area. All inquiries confidential. Call Commonwealth Group (313) 288-0022.

USED MEDICAL EQUIPMENT — used Varian 3000 Ultrasonograph with viewing cart and accessories. Good condition. $10,000. Contact

Dan Duval, Director, Non-Invasive Cardiology Services (517) 790-6914.

USED MEDICAL EQUIPMENT FOR SALE (LIKE NEW) — Welch Allyn Wall Transformer #74710 Halogen Handles, list $249.75. **$150** (two units); Welch Allyn Opthalmoscope heads #11610 Halogen, list $114. **$70** (two units); Welch Allyn Otoscope head #2000 Halogen, list $61.20. **$40** (one unit); Ear gavage set Pump type with tubing and ear spec., list $65. **$40;** Sony Micro Transcriber BM-715 with foot control and headset, list $350. **$225.** Call (517) 337-7792.

PRACTICE TO BUY OR SELL? Practice brokerage is our only business. Statewide service. CALL MICHIGAN PRACTICE BROKERAGE CORPORATION. (313) 827-8874.

DOCTOR, YOU CAN'T BEAT THE QUALITY OR THE PRICE! Holter Monitor scanning service. Physician owned, trained and supervised. $35.00 for cassette reports; $45.00 for reel to reel reports; no contracts to sign. We can arrange for lease/purchase of holter equipment. Why are you paying more and getting less? DCG Interpretation (313) 879-8860.

VIRGIN ISLAND CONDOMINIUM in St. Thomas for rent. Two bedrooms; 25 foot balcony directly on the ocean. Three pools, tennis courts, gorgeous beach and duty-free shopping. List of medical meetings available. Reduced air fares. $180.00 per night, 12-15-83 to 4-15-84; $100.00 per night, 4-15-84 to 12-15-84. Call Dr. Marshall collect at (313) 478-2739, days or (313) 471-7070, nights.

PROFESSIONAL RESUME SERVICES, 1125 South Cedar Crest Boulevard, Allentown, Pennsylvania 18103. We provide resume preparation for physicians. All specialties. Prompt and confidential. Call or write for information. (215) 433-4112.

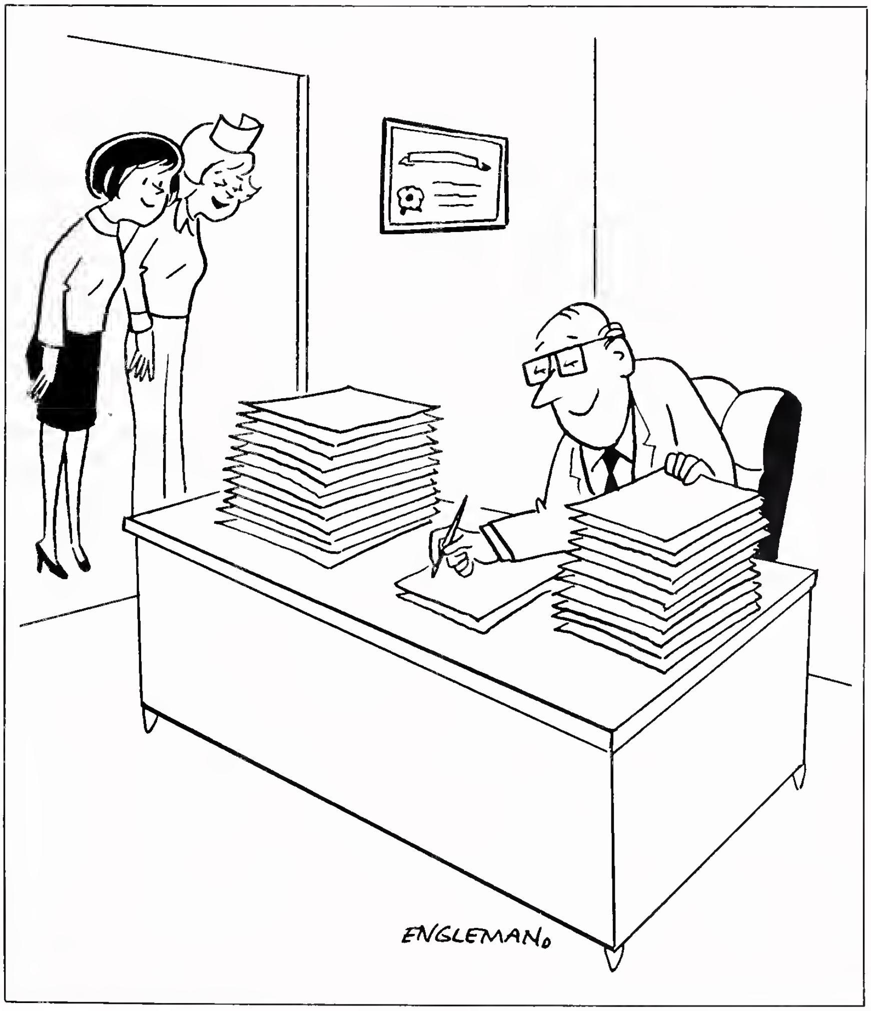
ATTENTION DOCTORS: We have previously owned medical, laboratory, office and x-ray equipment in excellent condition. We buy, sell, trade, move and repair. Office appraisals available by certified surgical consultants. Call Doctor Medical Resale at 313-569-4407, 9 am-9 pm.

LEASE MEDICAL EQUIPMENT — You select. $2,000 to $100,000. Why tie up cash or credit? Call for quote. Medical Leasing Co. 313-879-8860.

PHYSICIANS SIGNATURE LOANS TO $50,000. Up to 7 years to repay. No repayment penalties. Prompt, courteous service. Competitive fixed rate, with no points, fees or charges of any kind. Physicians Service Association, Atlanta, GA. Toll-free (800) 241-6905.

MEDICAL OFFICE SPACE — Upper Peninsula, Laurium. Deluxe office space, reasonable rent, 3 treatment rooms. For details, contact: Dr. Victor Lepisto, 210 Quincy Street, Hancock, Michigan 49930. (906) 482-5230.

BONITA SPRINGS, FLORIDA — 2 bedrooms, 2 bath condos perfect location between Naples and Ft. Myers. Convenient to beach, shopping and sight seeing. Completely equipped with washer-dryer, all linens. Weekly, monthly or by the season. C. L. Zeller, MD, (616) 344-0988.



"He's a real old fashioned doctor . . . does all the paperwork himself . . .!"

DEATHS/Continued

James R. Smith, MD
Petoskey

James R. Smith, MD, Petoskey internist, died September 15. He was 55. Doctor Smith was a 1952 graduate of the medical school at the University of Virginia. He had been affiliated with Little Traverse Hospital and Burns Clinic, and had a subspecialty in hematology. Doctor Smith was a US Army Medical Corps veteran, and served as a surgeon in Okinawa.

James A. Thomas, MD
Clearwater, Florida

James A. Thomas, MD, formerly of Coldwater, died August 31 at the age of 88. He earned his MD degree at Case Western Reserve University School of Medicine in 1933, and was affiliated with Branch County Health Center. Doctor Thomas was a former president of the Branch County Medical Society, and was a member of the American Academy of Ophthalmology and Otolaryngology and the Detroit Ophthalmological Society.

Thanks to our advertisers

Advance Medical & Research	25
AIDS	13
Blue Cross Blue Shield	11
Brown Pharmaceuticals	9
Burroughs-Wellcome	15
Campbell Labs	40
Computer Systems	32
HMI Industries	30
Health Care News	33
Kaplan Educational Center	30
Lab of Clinical Medicine	41
Lilly	31
Maternal and Perinatal Health Conference	IFC
Medical Protective	43
Mediclinics	39
MDPAC	3
MPMLC	18-19
MSMS Sports Medicine Conference	41
Naples Research and Counseling	35
Pfizer	36-37
PICOM	7
Reed Office Systems	43
Roche	IBC, BC
Stratton-Cheeseman	27
Upjohn	38

Profession must act on physician surplus

You do not have to be a student of the Graduate Medical Education National Advisory Committee (GMENAC) study to realize there is a rapidly developing surplus of physicians in the country and in our state.

All you have to do is ask your colleagues how their business is going, or attend a practice management seminar and talk to physicians looking for ways to improve their practice, and you will know that the surplus of physicians and its resulting competition is upon us.

Many physicians have blamed the slow economy for their decrease in practice load, looking forward to the time when the economy improves and their practices become busy again. Unfortunately, the surplus in physicians, their maldistribution, and the declining demand for medical services will prevent many physicians from reclaiming practice loads they experienced in the past.

An assumption formerly used is that market forces will cause a redistribution of physicians into underserved areas of the state and improve both access and quality of care. Two studies by Arbor Associates, "Physician Distribution in Northeastern Lower Michigan," and "Primary Care Physician Distribution in the Upper Peninsula of Michigan," published in 1983, show an increase of total physicians to population from 87.2 to 106.7 per 100,000 between 1976 and 1982. However, there was a decline of primary care physicians from 58.8 to 55.0 per 100,000 in the same period. A study by Rand Corporation in 1980 showed that the number of specialists relative to population increased more rapidly in smaller towns and cities than in larger metropolitan areas.

Donald K. Crandall, MD
MSMS President

One could conclude from these studies that market forces are causing a redistribution of physicians to underserved areas of the country. However, if one looks at distribution of primary care physicians and specialists, using standards for minimum and ideal levels, one may draw different conclusions.

I would like you to look with me at a recent study, "Further Increases In The Physician Supply Will Do Little To Improve Access To Health Services," released by the Office of Health and Medical Affairs, Michigan Department of Management and Budget (MDMB), to determine the impact of increasing numbers of physicians in Michigan.

The MDMB has established a need for 138 physicians per 100,000 population, with 72 of the 138 engaged in primary care. Yet, since 1961 there has been a decline in the number of counties meeting this minimum standard. During the 20-year period from 1961 to 1980 there has been a 50 percent increase in the number of physicians in the state, from 114 to 171 per 100,000 population. Seventy percent of these physicians were absorbed by urban areas, with 33 percent going to Oakland County alone. The number of counties with over 160 physicians per 100,000 persons increased from four to 11, yet the number of counties with fewer than 71 physicians per 100,000 increased by one.

A "fair share" distribution of physicians based on county population and the number of physicians was examined in this study. A value of 1.00 would mean that a county had its "fair share" of physicians. The county with the greatest number of physicians per population was Washtenaw County with 3.16, followed by Emmet with 2.31. Other counties with one and a half times their "fair share" of physicians were Oakland (1.76), Ingham (1.53), and Grand Traverse (1.53). Wayne County had 1.06, and Macomb County 0.66. Fifty-nine counties (75 percent) were worse off in 1980 than in 1961.

With the distribution of physicians becoming more uneven from 1961 to 1980, health planners are unwilling to depend on market forces to correct the maldistribution of physicians in Michigan. "Politically acceptable" alternatives to the market force fall into three areas. The first would be to limit residency programs to the number and type of needed specialists in the state. A second proposal would be to decrease the number of medical school openings to the projected needs of the state. The third proposal would be to increase tuition in medical schools and subsidize students willing to give a number of years of service in shortage areas.

The medical profession responded to a perceived shortage of physicians in the 1960s by expanding medical school enrollments. Yet we are reluctant to respond to the physician surplus projected by the GMENAC study. It becomes apparent from the study by the Office of Health and Medical Affairs, that if the profession fails to act on the physician surplus, the health planners will.

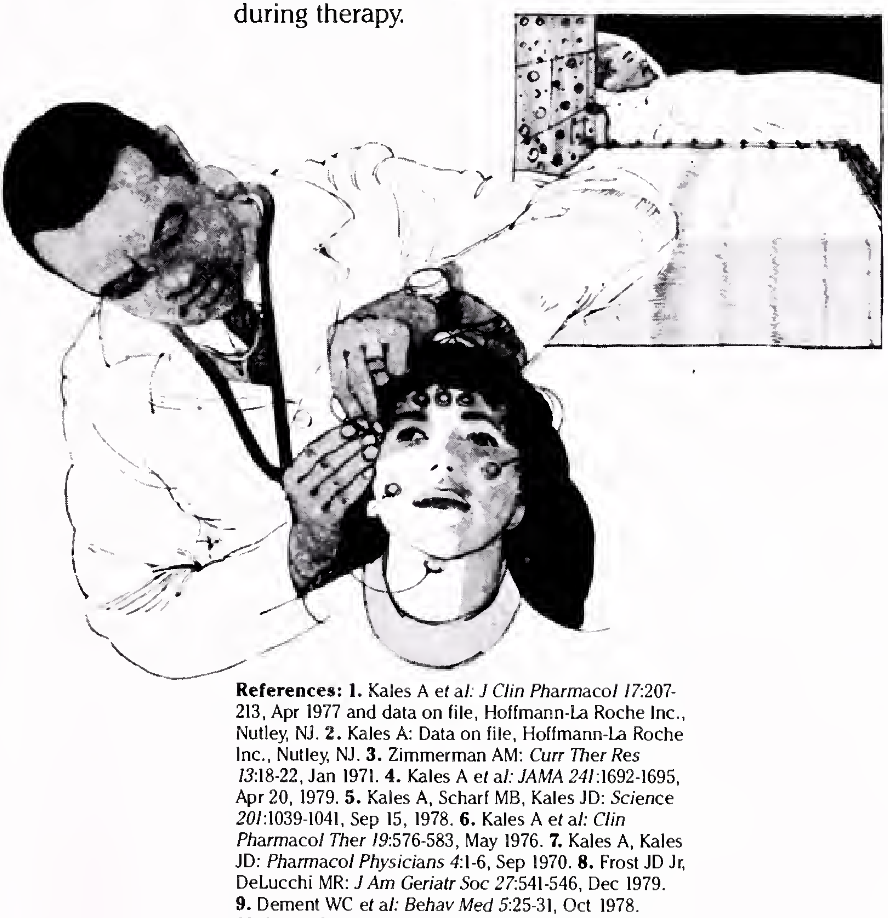
The weight of objective evidence supports the clinical efficacy of

Dalmane® ⓘⓥ

flurazepam HCl/Roche

15-mg/30-mg capsules

- Studied extensively in the sleep laboratory—the most valid environment for measuring hypnotic efficacy.[1-12]
- Studied in over 200 clinical trials involving over 10,000 patients.[13]
- During long-term therapy, which is seldom required, periodic blood, kidney and liver function tests should be performed.
- Contraindicated in patients who are pregnant or hypersensitive to flurazepam.
- Caution patients about drinking alcohol, driving or operating hazardous machinery during therapy.



References: **1.** Kales A *et al: J Clin Pharmacol 17*:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. **2.** Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **3.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **4.** Kales A *et al: JAMA 241*:1692-1695, Apr 20, 1979. **5.** Kales A, Scharf MB, Kales JD: *Science 201*:1039-1041, Sep 15, 1978. **6.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **7.** Kales A, Kales JD: *Pharmacol Physicians 4*:1-6, Sep 1970. **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **9.** Dement WC *et al: Behav Med 5*:25-31, Oct 1978. **10.** Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **11.** Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. **12.** Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. **13.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

Dalmane® ⓘⓥ
(flurazepam HCl/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

Contemporary Hypnotic Therapy

Dalmane® [flurazepam HCl/Roche] Stands Apart

Only one sleep medication objectively fulfills all these important criteria:

225 0000000000 .123184
SERIALS DEPT - LIBRARY
COLLEGE OF PHYS OF PHILA
19 SOUTH 22ND STREET
PHILADELPHIA, PA 19103

- Rapid onset of sleep.[1]
- More total sleep time on the first 3 nights of therapy.[1]
- More total sleep time on nights 12 to 14 of therapy.[1]
- Continued efficacy for at least 28 nights.[2]
- Seldom produces morning hangover.[3]
- Avoids rebound insomnia when therapy is discontinued.[1,4,5]

15-mg/30-mg capsules

Dalmane® Ⓘⓥ
flurazepam HCl/Roche

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

Copyright © 1984 by Roche Products Inc. All rights reserved.

Please see summary of product information on reverse side.

MICHIGAN MEDICINE

February 1984 JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Volume 83, Number 8

Michigan physicians and child abuse

Michigan Conference
on Maternal and
Perinatal Health

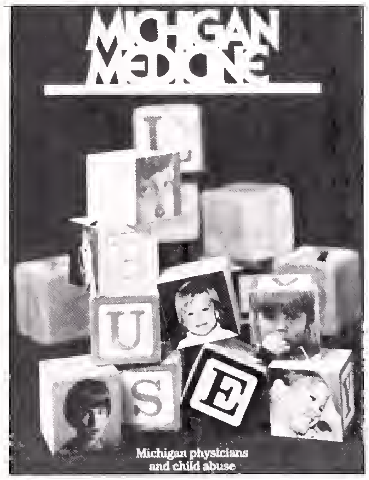
1984
Old Problems, New Solutions

March 28-29 Hyatt Regency Dearborn

For details: Michigan State Medical Society, P.O. Box 950, East Lansing, MI 48823 (517) 337-1351

February 1984, Vol. 83, No. 8

MICHIGAN MEDICINE



About the cover

The subject of this month's special report is child abuse in Michigan, and the part Michigan physicians may play in reducing its incidence. **Photo by Kim Kauffman.**

SPECIAL REPORT

50 From the tender scene of mother and baby on our January cover to the ominous representation of child abuse on this month's cover is a long way. But the two themes are of course related: one the ideal, the nurturing, warm, happy goal for each baby born; the other the harsh reality of life for too many Michigan children. The MSMS Committee on Child Abuse and Neglect is committed to helping physicians assure the former, and to helping responsible adults eliminate the latter. MSMS goals, the situation in Michigan, and the possibilities for physician action are spelled out in this month's special report; Douglas A. Sargent, MD, JD; Brooker L. Masters, MD; Barbara Meyer Lucas, MD; Dennis A. Wagner, MD; and Ray E. Helfer, MD

FEATURES

66 The status of 30 pieces of pending state health care legislation, with MSMS stands

82 How the AMA views government's health care proposals; Lonnie R. Bristow, MD

90 Doctor Powsner a dynamic role model; Martha Climo

98 Financial planning: Thoughts for the beginning investor; Katharine S. Brown

DEPARTMENTS

48 In my opinion; Karl J. Edelman

49 Letters

79 News

92 Board of Medicine

94 Medical newsfronts

100 Meetings
New members

102 Category I courses

106 Classified ads

107 Advertisers' index

108 President's page; Louis R. Zako, MD

LIBRARY OF THE
LLEGE OF PHYSICIANS
OF PHILADELPHIA
MAR 7 - 1984

IN MY OPINION

A Student's View

(Reprinted, with permission, from the Washtenaw County Medical Society Bulletin.*)*

By Karl J. Edelman

Why do medical students join the AMA? What is so intriguing about an organization that causes a medical student to take time from busy study and class schedules to take part in AMA functions? There are many reasons why I joined the AMA, not the least of which was to get to know fellow physicians in Washtenaw County and the State of Michigan.

But there are several more reasons why I joined the AMA. Very often, the medical student's perspective becomes narrow from concentration on exams or other requirements. Most waking hours are spent in classrooms and laboratories, causing us to lose touch with the real world. I consider this to be very unfortunate and something I personally cannot tolerate. By staying in touch with the rest of medicine through JAMA, the AMA News, Michigan Medicine, or the County Bulletin, I can at least be cognizant of the turbulent and often fast-paced events that are taking place in Medicine. By staying informed, when an issue of importance to me is raised, I can respond appropriately.

Another reason for current medical student involvement in the AMA is the increasing political scene on medicine. Rapidly changing governmental regulations and alteration of fee structures, as well as radical proposals for tuition increases, bear directly on our education and future practice of medicine. Involvement in the AMA, either as committee members or as individuals, allows us the opportunity to influence decision-making.

In addition to helping influence public policy concerning the practice of medicine, something that can be accomplished only through an organization the size of the AMA, my colleagues and I have become involved so that we may have some influence over medical education. To that end, efforts are now being made to set up one and two day perceptorship visits for medical students so that we may better see what real-life medicine entails rather than only university hospital-based practice. In addition, groups are looking into curriculum changes, tuition costs and alternate ways to finance medical education. All of these are reasons why we have decided to become involved in the AMA.

Finally, one of the primary reasons I joined the AMA was to be able to work with, and possibly some day help lead, the most prominent organization in the field I have chosen to enter. The AMA's potential for national leadership, in my view, has yet to be fully recognized. We, as medical students and future physicians, owe a debt to society that extends beyond repayment of our student loans. We have training in social interaction, economics, psychology, and diplomacy that are unparalleled in almost any other course of instruction in the world today. It is my firm belief that we must use our collective education for the benefit of America and all the people who have not been as fortunate as we to have had this educational opportunity.

The AMA offers me, as a medical student, much more than I can yet offer it; however, through continuing work I hope that I can gain experience that will enable me to help influence my future through the AMA.

Mr. Edelman is a University of Michigan Medical School student.

Michigan State Medical Society
Warren F. Tryloff, director

Committee on Publications
Busharat Ahmad, MD, Marquette, chairman
Harvey Andre, MD, Grand Rapids
Vickers C. Hansen, MD, Manistee
Leland E. Holly II, MD
Donald N. Sweeny, MD
James H. Tisdel, MD, Port Huron

Editor
Judith Marr

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

MICHIGAN MEDICINE (ISSN 0026-2293) is the official journal of the Michigan State Medical Society, published under the direction of the Publications Committee. Published five times a month, 60 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $30.00; single copies, $1.50. Additional postage: Canada, $1 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to articles, news, exchanges, should be addressed to Judith Marr, advertising inquiries to Joyce Crum and address changes to Peg Berry, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517-337-1351.

©1984 Michigan State Medical Society

World Medical Relief

Could you please send me the address of World Medical Relief? I have a lot of sample medicines that it seems to me they could use. There also are some medical instruments they may like to have.

Mary O. Anderson, MD
Leonidas

Editor's note: For the benefit of other Michigan physicians who might wish to contribute used or surplus medical supplies to the organization, here is the address:

World Medical Relief
11745 Twelfth St.
Detroit, MI 48206

Critical Care Society

North Central Critical Care Society has been organized for those involved in critical care medicine. Our goal is to promote educational opportunities for all members. There will be a meeting in 1984 during the month of May in Minneapolis for all interested. Further details of this meeting will be announced in early spring.

If you or any of your colleagues are interested in membership in this organization, please contact: Richard M. Sweet, MD, secretary-treasurer, 2545 Chicago Avenue So., Suite 610, Minneapolis, Minnesota 55404, for further details.

Richard M. Sweet, MD
Secretary-Treasurer
North Central
Critical Care Society
Minneapolis

MSMS Brochure

On behalf of the Judicial Council of the American Medical Association, we would like to express our compliments on your excellent pamphlet entitled "If You and Your Doctor Have a Problem." We would appreciate receiving several extra copies of this pamphlet for our reference files.

Mary M. Devlin
AMA Office of
the General Counsel

Editor's note: Single copies of the brochure are free to MSMS members. Fifty copies are $5 and multiples of 100 can be ordered for $8. Please send check payable to MSMS, PO Box 950, East Lansing 48823. (Attn.: Vada Davis)

Seat belts

Congratulations on the superb coverage on safety belts in the October 1983 *MICHIGAN MEDICINE.* The material presented should be very valuable in securing even more physician support of the proposed legislation.

I would be grateful for five copies of the journal if that can be arranged.

As you may remember, the American Association for Automotive Medicine with the Medical Society of the State of New York has established the New York Coalition for Safety Belt Use. The New York approach is somewhat different from Michigan's approach, but the goal of a safety belt use law is identical.

We will continue to keep abreast of Michigan's effort and help where we can.

Elaine Petrucelli
Executive Director
American Association
for Automotive Medicine

DEA number

An important question has been raised by a Genesee County physician which deserves a responsible answer and the cooperation of the medical community.

The question: **"Why are pharmacists calling to verify my prescriptions and asking about my so-called DEA number?"**

The DEA number, previously called the BNDD number, references the federal license number issued by the Drug Enforcement Administration (DEA). Physicians must obtain both a federal and a state DEA license to prescribe a special classification of prescription drugs known as "Controlled Substances."

In fact, there are four "schedules" of prescription drugs categorized as controlled substances, and a Schedule V classifying even certain nonprescription or over-the-counter (OTC) medications as controlled substances.

In similar fashion, a pharmacist and a pharmacy also must have DEA licenses to purchase and dispense controlled substances on the prescription of a professional who has a valid DEA license.

The pharmacy community is experiencing a virtual explosion in the incidences of persons attempting to obtain prescription drugs, most often controlled substances, through the use of stolen and forged prescription blanks and other more exotic schemes involving telephoned prescriptions.

The fact is, on more occasions than most people may be aware, pharmacists must distinguish between a valid prescription for a valid therapeutic need and an attempt to capitalize on the legitimate drug distribution system vis-a-vis a forged prescription, either written or verbal.

The DEA Number becomes an important component in verifying the validity of a prescription about which the pharmacist may be suspicious as to its authenticity.

The DEA number is important for another reason. It is a required element of information on the claim form for a patient covered for pharmacy services under third-party programs such as Blue Cross Blue Shield's.

"This information relative to the original question is provided to enhance inter-professional understanding of the distinct yet related factors impacting the practice of both medicine and pharmacy," Genesee County Pharmaceutical Association President Larry Cappel said. "It underscores the continuing importance for liaison and cooperation between pharmacy and medicine, both at the county and the state levels."

We pass it along to all Michigan physicians for their information.

Louis M. Sesti, Director
Michigan Pharmaceutical Association

George C. Punches, President
Michigan Pharmaceutical Association

By Douglas A. Sargent, MD, JD

The not-so-merry-go-round

Amber smiled at me from the newspaper clipping reporting her death.

In her short life, Amber had been through a lot. At 15 months a physician had reported her bruises to a child-protective agency. There a social worker neglected to question the physician and instead accepted the mother's alibi for the bruises.

Four months later employees reported fresh bruises they could not help but see when Amber toddled into a neighborhood bank. This time, unaccountably, the physician, too, accepted the mother's flimsy explanation: a fall from a merry-go-round.

A few months later the merry-go-round stopped for Amber; she was beaten to death by her mother's lover. But it did not stop for the child-protection system, which continues to spin out excuses for a basically inexcusable failure to protect the Ambers of this world. Physicians are a part of this system.

Familiar nausea

I read about Amber in a pile of clippings and articles as I prepared to chair an AMA Advisory Panel charged with reviving medicine's response to child abuse. I had not been directly involved with abuse for 15 years, though I once directed a juvenile court clinic where such cases were grimly commonplace. To bring myself abreast of the experts I was to lead, I now steeped myself in the professional literature on child abuse and neglect.

After only a few hours of review a familiar nausea began to underscore my reading. Here was the same old roster of outrages against helpless victims, the monotonous catalogue of cruelties inflicted by "caretakers" who, but for their ages, seemed more like vicious waifs than the parents they purported to be. I read more dreary recitations "justifying" what is really our failure to value children enough to save them from disaster. Except for a new emphasis on sexual abuse, the 17 years of my absence from the field had not changed the pathos of these tragedies nor the pervading sense of frustration at the ineffectual measures used to combat them.

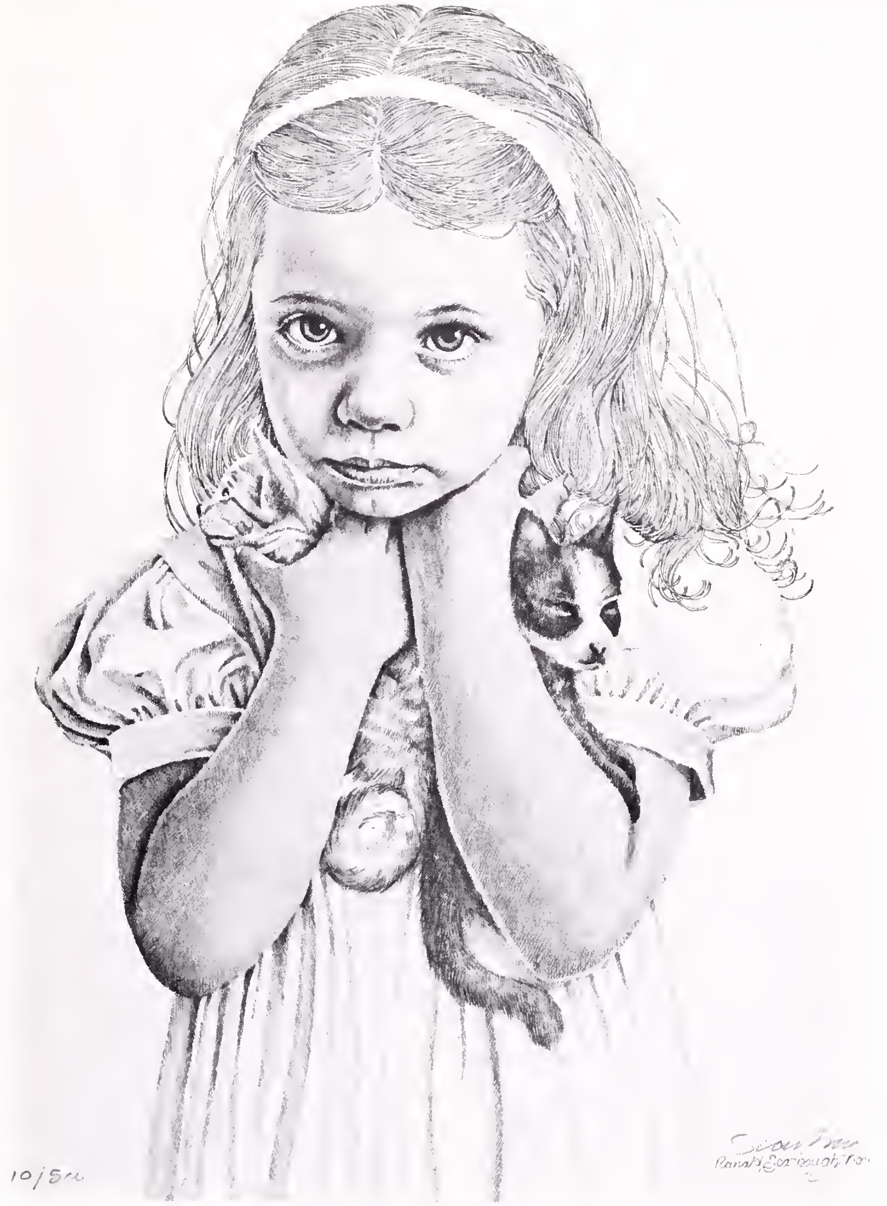
More important for me as a physician, medicine seemed to have withdrawn from the position of leadership it once occupied in the days when the work of C. Henry Kempe, MD made battered babies a matter of national concern. His book, *The Battered Child,* sparked child abuse reporting laws in every state. Since then physicians appear to have placed child abuse on the back burner, perhaps disillusioned by the protective system's inability to respond effectively when suspected abuse is reported.

It is true that medicine has contributed much to recognition of the problem. Very early, pediatricians reported x-rays signs distinguishing accidental trauma from the repeated injuries that characterize chronic abuse. Ophthalmologists and dentists are now alert to their special role in detecting inflicted injuries, which have a predilection for the face. The "kiddiegram," or total body x-ray, became routine for evaluating suspected abuse. Physicians identified the wasting produced by emotional deprivation, the vacant stare and developmental delay caused by repeated brutalization. Medical studies uncovered high-risk groups like premature babies and hyperactive or unwanted children. SCAN teams (an acronym for Suspected Child Abuse and Neglect) now evaluate all suspicious cases in most large hospitals. And yet physicians can and must do more.

Eugene Eldridge, MD, a pediatrician from Salinas, California, inspired the AMA to take stock of its own effectiveness in this area. The AMA surveyed state medical societies and learned that few of them had programs directed at Child Abuse. Many of these seemed "paper tigers." Despite universal mandatory reporting, physicians appear to be indifferent reporters of abuse. Moreover, physicians generally lack knowledge of groups at special risk, of the signs and symptoms of abuse and of the community resources available to rehabilitate abusive families. The panel clearly saw that medicine has to get its own house in order.

> **". . . physicians should be the gatekeepers of the child protection system . . ."**
>
> **— Brooker L. Masters, MD, Chairman**
> **MSMS Committee on Child Abuse and Neglect**

Doctor Sargent is chairman, Panel on Child Abuse, AMA Council on Scientific Affairs.



Artist Ron Scarbough, of Detroit, recently displayed and sold his drawings of children for the benefit of the Mt. Carmel Mercy Hospital Child Abuse and Neglect Prevention Program.

Gatekeeper asleep

While medicine is the gatekeeper of any system that attempts to control child abuse, too often the gatekeeper has seemed to be asleep. When we treat their injuries and diagnose the causes, we certify that children are, indeed, abused. We thus qualify children and their abusers for whatever help a community has provided them. The system depends upon informed, involved physicians for these vital tasks. But sometimes we fail to do our part. Although among physicians today there is widespread dissatisfaction with the adequacy of this "help," especially when the abuse is sexual, and although this discontent may seem to justify our failure to report, physicians cannot disregard a growing suspicion that our own knowledge and skills need upgrading. At its first meeting the panel decided that a major initiative was needed to re-educate and rededicate physicians.

To launch this effort, the AMA will hold a national conference for medical leaders March 30 and 31 in Chicago. Experts in relevant disciplines will give a continuing medical education course in the detection, treatment, rehabilitation and prevention of abuse. The students will be physicians representing state and county medical societies and national medical organizations. It is expected that these physicians will transmit their new learning to their colleagues when they return to their "home societies," catalyzing them to play their parts effectively in the multidisciplinary effort against child abuse.

Although many physicians are natural leaders, in this field we must learn to become effective team players. The solo physician attempting to cope with the abusive family is impotent. Today medicine agrees with James Baldwin's mordant observation: it takes a whole village to stop child abuse.

By Brooker L. Masters, MD

The pressing need is for coordination

The MSMS Committee on Child Abuse/Neglect welcomes the decision by the editors of *Michigan Medicine* to focus this issue on the problem of child abuse and neglect in our society.

Since its formation in 1982 this committee has been actively studying this vexing issue through a series of meetings with civil and government experts. The result has been to achieve a consciousness of a multitude of perplexities and many more problems than answers. We have decided, however, that we can perhaps do *something* to start removing this blight on our society.

Paramount in our deliberations thus far is the loud cry for involvement of the medical profession. For reasons not altogether clear, physicians as a group have defaulted any meaningful involvement in this little understood field. All agencies that are involved are persistent in their stated need for our participation. The committee members feel that we, as medical directors for the entire health care system, must address this default.

Michigan Public Act 238 of 1975 *requires* that physicians dealing with abused or neglected children must report their findings to the nearest department of social services. A person who fails to do so is civilly liable for the damages proximately caused by the failure to report and also is guilty of a misdemeanor.

But it is much more than a need to conform to a law. Physicians often are the first line of succor for these abused and neglected children who really are helpless in the face of this threat to their well-being, and, yes, even their lives.

When one realizes that 90 percent of the inmates of our prisons, and 90 percent of the adults who are abusers, once also were abused or neglected children themselves, one can begin to grasp the enormity of the costs of this tragedy, not to mention the countless blighted lives which result from it.

The goals of our committee expand with every meeting. Primarily the aim is to educate physicians on their responsibilities to their patients, and to provide guidelines for recognizing child abuse.

In cooperation with the MSMS Committee on Aging, we have produced a pamphlet — "The Abused Patient and the Doctor's Responsibility." It is available without cost from MSMS headquarters. (A single copy is bound with this issue.) Members of the committee are available for programs at county medical society meetings or for any other group interested in the problem.

Much activity goes forward in initiating legislation and is testimony before legislative committees regarding bills dealing with these issues. The State Health Plan is being revised to reflect current efforts in this regard.

The awareness is emerging that there is a pressing need for coordination of all the many agencies and groups who are working in the field. Presently social agencies and volunteer advocacy groups of all kinds are expending much energy, but almost no one knows what the others are doing.

It seems logical that physicians should be the gatekeepers of the child protection system and, therefore, might be the logical choice to synchronize all these efforts. It is our hope that we might achieve such a consensus by the physicians of Michigan.

Identification and reporting of child abuse and neglect are important. Protecting the affected children is an obvious necessity. Understanding the causes of such inexplicable behavior and, even more, prevention, are critical. Statistics which show the incidence and severity of the beatings, molestations, and neglect are increasing at an alarming rate.

Michigan Medicine once again is assuming leadership by this symposium on this vital subject. It deserves the thoughtful appraisal of all physicians on behalf of their patients.

Doctor Masters is chairman, MSMS Committee on Child Abuse and Neglect. He also is a past president of MSMS.

By Barbara Meyer Lucas, MD

Multi-disciplinary teams hold children's best hope

Every year in the United States, more than 1,000,000 children are victims of child abuse or neglect, with at least 2,000 children dying from their injuries. Here in Michigan, from October 1982-September 1983, there were 38,429 substantiated victims of child abuse and neglect, an increase of 1,905 victims over the previous year. Fully 47 percent of these confirmed victims were children who were previously reported as abuse victims to protective services.

In Wayne County, where our Child Abuse and Neglect Prevention Program is based, there were 10,057 confirmed victims of child abuse and neglect in the past year, accounting for 26 percent of all the victims in the entire state. At our hospital, a 600 bed regional trauma and pediatric center in Northwest Detroit, we currently are receiving more than 40 referrals per month for assessment of possible abuse or neglect, which is more than twice the number of family referrals we were receiving in 1980.

Although the number of child abuse and neglect victims continues to rise each year, even more disturbing is the fact that the types of cases we are seeing are increasingly severe, with more cases involving torture and mutilation, more cases involving sexual abuse (even of very young infants and children), and more cases resulting in permanent disability, brain damage, or death of the child.

In light of this bleak picture, the AMA, the American Academy of Pediatrics, and several other professional organizations have targeted the problem of child abuse as a national priority to be addressed by the medical profession in the coming year, beginning with the establishment of child abuse committees within each state medical society. These committees have begun to call

Mount Carmel Mercy Hospital
Child Abuse and Neglect Prevention Program
Format for Presentation of SCAN Cases

- I. **Case history**
  - A. Physician report— resident, ER, and/or clinic physician
    - 1. Chief complaint, history and physical findings, reason for suspecting abuse or neglect; — if possible, bring x-rays, slides, photos.
    - 2. Diagnosis and problem list;
    - 3. Immediate management and care plan;
  - B. Nursing report — floor, ER, and/or clinic nurse
    - 1. Pertinent clinical and historical information about child;
    - 2. Nursing interactions with parent/guardian;
    - 3. Nursing observations about parent-child interaction;
  - C. Social service/crisis intervention report
    - 1. Historical data;
    - 2. Interaction with child and family members;
  - D. Child psychiatry/psychology report
    - 1. Evaluation of child;
    - 2. Evaluation of parent and/or family members;
  - E. Report from other disciplines (Child life, physical therapy, etc.)
  - F. Protective services report/police report
- II. **Formulation of SCAN team recommendations**
  - A. Physician recommendations
  - B. Nursing recommendations
  - C. Social service recommendations
  - D. Child psychiatrist recommendations
  - E. Other discipline recommendations
  - F. Protective services recommendations
- III. **Critique of handling of this case**
  - A. Sensitivity of team members to child and family
  - B. Adherence to SCAN protocol by team members and other personnel
  - C. Timely and appropriate intervention and reporting
- IV. **Establishment of future case review date for follow-up**

Doctor Lucas is a staff pediatrician at Mt. Carmel Mercy Hospital in Detroit, where she directs the Child Abuse and Neglect Prevention Program. Doctor Lucas is a member of the MSMS Child Abuse Committee, chairperson of the Child Advocacy Committee of the Michigan Chapter of the American Academy of Pediatrics, and a member of the board of directors of the Michigan Chapter of the National Committee for the Prevention of Child Abuse and Neglect.

Facts about child abuse

- In 1982, there were over 36,029 confirmed victims of child abuse/neglect in Michigan. These cases are the "tip of the iceberg," since most still go unreported. It is estimated that approximately *one out of 10 children suffers abuse or neglect.*
- More children under the age of five die from injuries inflicted by abusive parents than die from tuberculosis, whooping cough, polio, measles, diabetes, rheumatic fever and appendicitis combined.
- Child abuse and neglect have been correlated with truancy, runaways, drug and alcohol abuse, spouse assault, violent crimes and even mass murders. Michigan State Police report that 90 percent of inmates in state prisons for violent crimes were abused/neglected children.
- Child abuse/neglect are family problems passed on from one generation to the next. Studies have shown that 90 percent of abusive/neglectful parents were abused or neglected when they were children.
- A study done in Lansing found that 60 percent of substantiated cases occurred in single parent homes, 60 percent were low-income families and 40 percent were both.
- The costs of after-the-fact intervention are enormous, not only in obvious human suffering and lost potential of children, but in dollars. For example,

  Cost of foster care averages $7,847 per child per year — over $82 million each year in Michigan.

  Cost of institutional care for one permanently disabled child or "incorrigible youth" averages $23,068 per year/child.

  Cost of keeping one person in a state prison is estimated at $20,000/year.
- *Michigan's new Children's Trust Fund and Child Abuse Prevention Board* (PA 211, 249, 250 of 1982) offers new hope for child abuse prevention. Through a check-off on income tax forms, Michigan citizens now can donate $2 from their refund to support state-wide child abuse prevention services at the local level.

Sources: Michigan Department of Social Services, U.S. Department of Health and Human Services, 1979, Garbarino (1980), Council for Prevention of Child Abuse, Justice and Duncan (1980). For more information contact Sharon Shay, 517/484-8444.

COUNCIL FOR THE PREVENTION OF CHILD ABUSE AND NEGLECT
111 S. Capitol Ave., Suite 200,
P.O. Box 20247, Lansing, MI 48901

SCAN TEAMS/Continued

upon experts from a variety of professions concerned with child welfare in order to draft recommendations for physician involvement in responding to the problem of child abuse.

In the course of the MSMS Child Abuse Committee meetings during the past year, one clear need for physician involvement has already emerged: the need for the members of the medical profession to become active participants in locally sponsored multidisciplinary child abuse teams.

Many of these teams have been developed across the country over the past several years, under a variety of acronyms: e.g., the CPT (child protection team); the MDT (multidisciplinary team); or most commonly, the SCAN Team (for suspected child abuse and neglect team).

Depending on their communities' needs, these teams may be hospital-based, university-based, or free-floating over an entire county. Regardless of their name or affiliation, however, most child abuse teams share many of the following features.

Components of an effective team

At a minimum, the establishment of an effective local child abuse team depends on four essential elements: **team composition, written protocols, assessment tools,** and **community backing,** all of which can depend greatly on the extent of local physician involvement.

The **team composition** should be multidisciplinary, including at least one physician, a nurse, a social worker, an attorney, a protective services worker, and someone from the behavioral sciences; all of these professionals should have training or experience in the area of child health or welfare.

Additionally, team members should be selected from a variety of service areas: i.e., perhaps a physician in private practice, an emergency room nurse, or a social worker from a clinic setting, etc. This provides an additional depth of experience and broadening of the team's credibility in responding to suspected cases from a variety of referral sources. Forethought also must be given to selecting at least a subgroup of team members who can be available on an emergency basis to assess urgent cases which cannot wait for a regularly scheduled team meeting.

At Mount Carmel, our SCAN Team has been functioning since 1977, with the following current membership: one staff pediatrician, one ER pediatrician, a child psychiatrist and child psychologist, two pediatric nurses, one psychiatric nurse, two social workers, one chaplain, a physician's assistant from the developmental medicine program, a protective services supervisor,

Continued on page 56

THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android®/5 mg. Buccal/10 mg. Oral/25 mg. Oral
Methyltestosterone U.S.P. Tablets

ANDROID®/F
Fluoxymesterone U.S.P. Tablets, 10 mg.

and an attorney from the juvenile defender's office.

Written protocols should be developed to provide a consistent and medically sound manner of handling suspected abuse and neglect cases; again, a trained physician's input is essential. Depending on the scope of the team's functions, protocols may be as simple as a case review format or as detailed as mandatory policy for all hospital personnel managing these cases. Mt. Carmel's SCAN Team has an established protocol, approved by the medical staff, in place on all units dealing with children. The SCAN protocol details physician, social work, and nursing responsibilities; special instructions for sexual abuse cases; guidelines for documentation of injuries and preservation of evidence; and procedures for interacting with the police and the courts.

Assessment tools for teams include Polaroid cameras or access to a good medical photographer for documentation of injuries; body injury maps and pediatric growth charts; and a set of anatomically correct dolls for use in suspected sexual abuse cases. Secretarial support and a confidential record-keeping system are also essential to document all SCAN team assessments and case review meetings.

Community backing and/or hospital administration support are of course critical to the establishment of any local team. At present, most teams consist of volunteers, although state funding for at least one team in each county is being pursued.

Possible functions of a local team

Depending on the needs of a particular community, there are at least six different functions a child abuse team may perform.

(1) **Regular SCAN case review:** An established team usually meets on a regular basis to review those cases which have been reported as suspicious for abuse or neglect in their community. The purpose of the meeting is to evaluate the case, determine whether it is likely that abuse or neglect occurred, and make recommendations to the appropriate authorities or agencies working on behalf of the child and the family. Depending on the volume of cases seen in the community, the team may review all cases reported since their previous meeting, or only selected cases which were particularly severe or difficult to manage. At Mt. Carmel, our SCAN team meets weeky for an overview of all cases referred in the previous week; one or two cases are then presented for review and recommendations by the entire team.

Each case review is conducted according to an established format, which is included with this article. The team recommendations are then forwarded to protective services, and a follow-up review date is established to be sure the management plan is being implemented on behalf of the child.

(2) **Emergency case assessment:** Child abuse team members may decide to make themselves available for emergency assessment of cases.

In our hospital, a SCAN team member is available at all times by long-range beeper, on a rotational call basis. That team member follows the SCAN protocol and notifies other appropriate team members to assist in the case assessment, depending on the particulars of that case. The on-call member is also responsible for notifying protective services, ensuring adequate documentation of the child's condition, and arranging for a detaining order if that should be necessary for the child's safety. In all cases of serious injury or death of a child, a SCAN team physician is called immediately to the hospital.

(3) **Consultative services:** An established team may elect to offer their case review services or emergency response services to other health care providers in neighboring facilities or counties.

(4) **Education and training of other professionals:** Team members, particularly physicians, may be willing to share their expertise with other professionals dealing with abuse and neglect. At Mt. Carmel, all SCAN team members participate in a semiannual series of inservice sessions for hospital personnel, with each team member providing training to his or her respective departmental staff. Additionally, our team provides annual training to the Detroit Police Department, the Wayne County Prosecutor's Office, and the county Department of Social Services. Currently, efforts are being made by MSMS and the Michigan Chapter of the American Academy of Pediatrics to recruit interested physicians willing to help train protective services workers across the state.

(5) **Community education:** A local child abuse team can become a valuable tool to heighten a community's awareness of the serious problem of child abuse. The team well may become a mobilizing force to encourage a community to look at the preventive measures they might take on behalf of their children and families.

(6) **Child advocacy:** Multidisciplinary teams, and particularly the physicians who participate on them, may work for legislative and judicial reforms to better protect the children of our state. Suggested reforms may be processed through the legislative liaison of the MSMS Child Abuse Committee, or directly through your elected congressmen.

By Dennis A. Wagner, MD

Medical examiners vital link in detection and prevention

Child abuse and neglect continue to be major problems in our society, with estimates of 2,000 resulting deaths per year in the United States.

And all reports seem to indicate that the incidence is far higher than those cases actually reported. Public awareness, and particularly physician awareness, has increased the reporting of actual cases of abuse and neglect.

Unfortunately this is not always the case, and an uncomfortable number of cases still are missed, only to be discovered when the child is finally killed.

The county medical examiner thus becomes a vital link, not only in detecting child abuse, but also in protecting the siblings and other children who might come under similar assault.

Studies indicate that approximately 10 percent of the children hospitalized for child abuse eventually die from this battered child syndrome. Child abuse remains the second leading cause of death, behind only sudden infant death syndrome, in children under the age of one, and second only to accidents in older children.

The team

Because of this the Michigan State Medical Society Committee on Child Abuse and Neglect has recognized the importance of including the medical examiner in the overall team of child protection. The committee also recognizes a lack of educational programs available to medical examiners in the state. To aid progress in this difficult area, the committee recently has sent a questionnaire to all the chief medical examiners.

Persons who actually participate in suspected child abuse and neglect investigations are concerned many cases are missed, particularly when the diagnosis is accidental death. The fatally injured child usually is less than one year of age, usually succumbs to head injuries and may not show other signs of chronic abuse, such as one might find in an older child who has been repeatedly assaulted.

It is of note that a child's fall rarely produces significant head injuries. In fact, one study of 246 falls in children less than five years of age revealed no occurrence of serious cerebral injury if the fall was three feet or less. Another study of falls greater than 10 feet concurred that none of those children sustained serious brain injury and thus one must be suspicious of a history of a child falling to the floor and sustaining a significant brain injury.

A second area of concern is childhood suicide. Suicide rarely occurs in children under the age of five and the vast majority of cases range in the 10- to 14-year age group. It is extremely important that even though the cause of death may be obvious, investigators look thoroughly for underlying factors, especially signs of repeated physical or sexual abuse.

And, finally, the most difficult area involves sudden infant death syndrome (SIDS). Certainly only a small percentage of infants diagnosed as expiring from this disease have actually been the victims of homocidal smothering, but autopsy is essential to eliminate this possibility. The literature seems to show a definitive cause of death is found at autopsy in approximately 15 percent of the

---

Doctor Wagner is a member, Michigan State Medical Society Committee of Child Abuse and Neglect, medical consultant to Midland Hospital on the Suspected Child Abuse and Neglect Team, and deputy medical examiner for Midland County.

MSMS survey uncovers MDs' child abuse reporting habits

In the late fall of 1983 several Michigan physicians participated in a survey to assess physicians' personal and professional attitudes about child abuse. The physicians were chosen at random from a list of MSMS members representing medical specialties of general practice, family practice, obstetrics-gynecology, internal medicine. The preliminary analysis of the data from 136 respondents provides some interesting insights.

Eighty-five percent of the physicians responding said they saw fewer than five cases of child abuse a year. Forty-two percent of the respondents said they saw no child abuse cases in a year. As expected, the detection of child abuse varied by specialty. The percent of respondents by specialty who indicated that they did not see any child abuse cases in the course of a year is: internal medicine — 92 percent; ob-gyn — 66 percent; family practice and general practice — 17 percent; pediatrics — 14 percent; emergency medicine — 12 percent.

When asked about reporting of child abuse cases, 69 percent of respondents indicated they always report child abuse. This compared to 77 percent of respondents who stated they believed that child abuse should always be reported by physicians. Five percent of respondents said they seldom report child abuse and eight percent indicated they never report child abuse cases. Eighty-nine percent of those indicating they never report child abuse were in the specialty of obstetrics-gynecology or internal medicine.

When asked about the factors that influenced their decision to report child abuse, significant numbers of respondents indicated that they are less likely to report child abuse when they feel child abuse was accidental (60 percent), they feel that reporting will only make matters worse (54 percent), or they only see the patient for consultation purposes (49 percent). Respondents indicated they are most likely to report child abuse when the parents express anger toward the doctor (83 percent), when they think they might have to testify in court (80 percent) or when they are uncertain how the injuries were inflicted (72 percent).

Of the 136 respondents, 46 percent said they receive help from a nurse in identifying and reporting child abuse and 40 percent stated they receive assistance from other physicians and from hospital social workers. Thirty-six percent stated they received assistance from community protection services. Forty-three percent of respondents stated that child abuse caused them a strong emotional reaction and 40 percent indicated feeling anger at the parent(s) inflicting the injuries.

The MSMS Committee on Child Abuse/Neglect wishes to thank those who participated in the survey.

EXAMINER/Continued

cases originally labeled as SIDS death. The autopsy has a major role not only in detecting abuse and neglect but more importantly, in serving as part of the support system necessary for the parents who have suffered such a tragic loss.

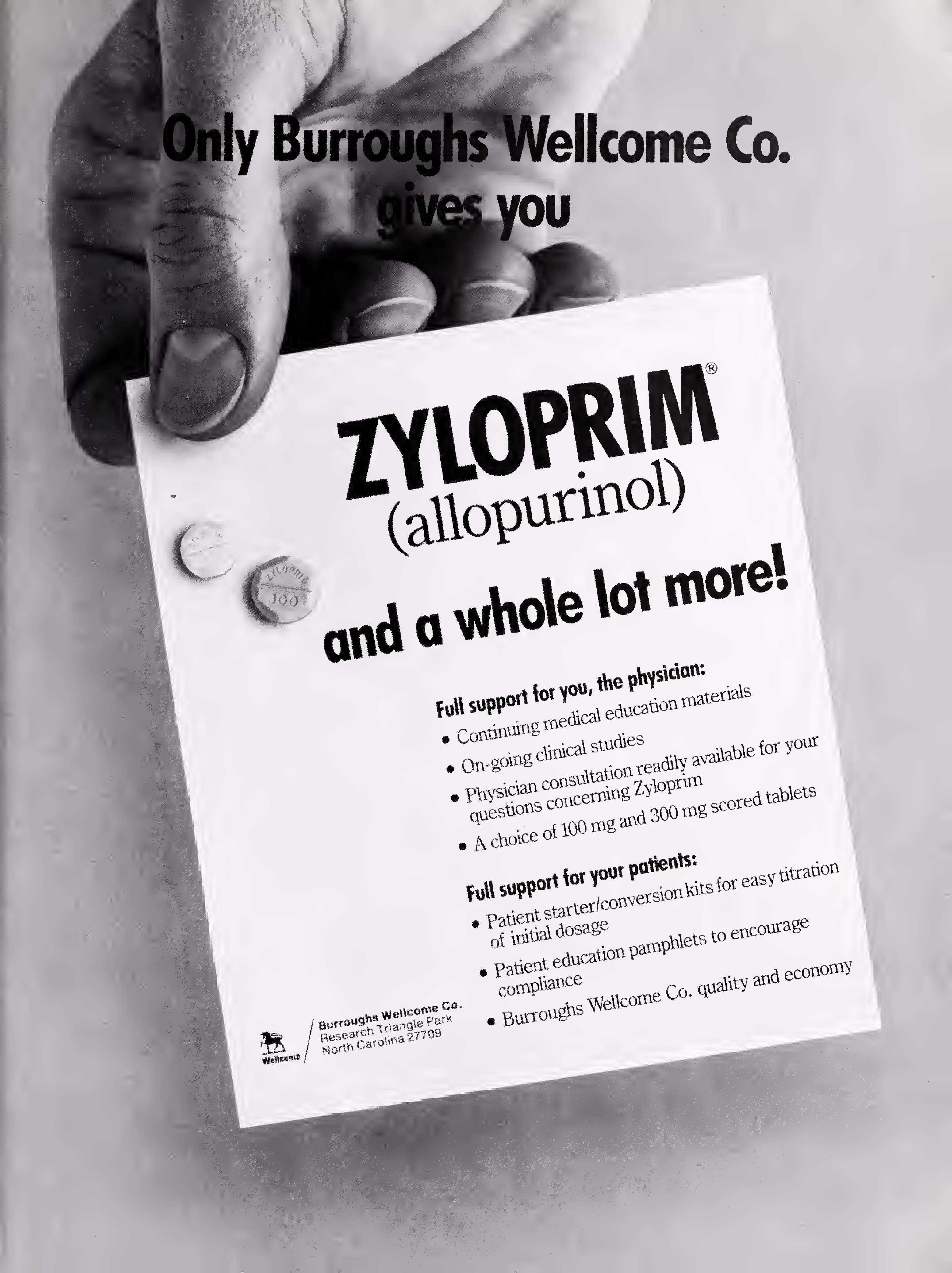
Going further

The medical examiner's mandated task is to determine the cause of death; but ethically and legally this investigation must go further in cases of suspected abuse and neglect. To aid the medical examiner in accomplishing this task the referring physician needs to provide his consultant with a complete history and results of his clinical exam prior to any post mortem examination. Family statements with regards to the mechanism of injury, particularly any that conflict must be made clear to the forensic pathologist. The physician should give the ME any available photos if there will be a long delay between the time of death and the post mortem examination. Whenever possible, the medical examiner should make an on-the-scene investigation. He should give special attention to documenting pattern bruising; signs of cigarette burns, tethering, and sexual abuse even if they are not a contributing factor to the cause of death. Routine bone surveys on all children prior to post mortem examination followed with direct examination of the growth plates of the long bones will be extremely important in documenting prior trauma. Available developmental data should also be provided for the medical examiner so he can determine if the child was capable of performing the tasks necessary to produce the injuries sustained.

The legislature is considering forming a state medical examiner's office responsible for training of county examiners.

The Michigan State Medical Society Committee on Child Abuse and Neglect has appropriately recognized the medical examiner as a vital link in preventing child abuse and neglect and has made the medical examiner a major focus in its coming educational programs.

(more on page 63)



Only Burroughs Wellcome Co. gives you

ZYLOPRIM®
(allopurinol)

and a whole lot more!

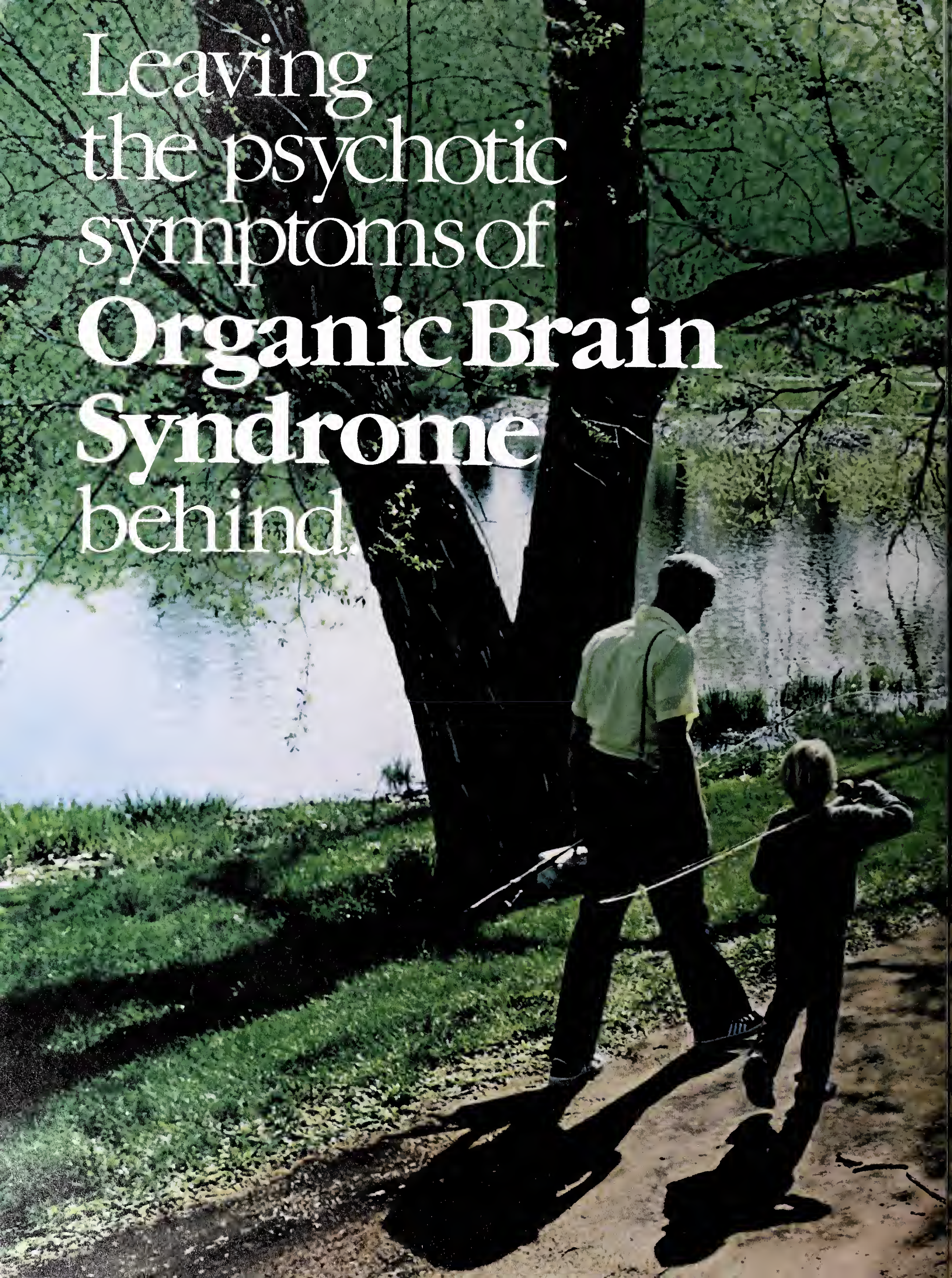
Full support for you, the physician:

- Continuing medical education materials
- On-going clinical studies
- Physician consultation readily available for your questions concerning Zyloprim
- A choice of 100 mg and 300 mg scored tablets

Full support for your patients:

- Patient starter/conversion kits for easy titration of initial dosage
- Patient education pamphlets to encourage compliance
- Burroughs Wellcome Co. quality and economy

Wellcome
Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709


Leaving the psychotic symptoms of **Organic Brain Syndrome** behind.

Effective

Treatment with Navane can produce improvement in psychotic symptoms such as hallucinatory behavior and unusual thought content as well as hostility, disorientation and depressive mood,[1,2] leaving the elderly patient more alert[2] and better able to participate in the activities of family life.

Well tolerated

Navane is generally well tolerated by elderly patients. Excessive sedation or drowsiness has been reported, but is uncommon.[1] Anticholinergic effects[3] and hypotension[4,5] are reported, but rarely. Should they occur, extrapyramidal symptoms can usually be readily controlled.

Navane®

(thiothixene) (thiothixene HCl)

Capsules 1 mg, 2 mg, 5 mg, 10 mg, 20 mg
Concentrate 5 mg/ml Intramuscular 2 mg/ml, 5 mg/ml

See following page for a brief summary of prescribing information

© 1982, Pfizer Inc.

ROERIG *Pfizer*
A division of Pfizer Pharmaceuticals
at the forefront of psychopharmacology

Navane®
(thiothixene) (thiothixene HCl)

References: 1. Util TM, Unverdi C. Wohlrade J, et al: Drug therapy of psychosis associated with organic brain syndrome. Presented as a Scientific Exhibit at the American Public Health Association Centennial, Atlantic City, New Jersey, November 12-16, 1972. 2. Katz MM, Util TM: Video methodology for research in psychopathology and psychopharmacology. *Arch Gen Psychiatry* 31:204-210, 1974. 3. Ketai R. Psychotropic drugs in the management of psychiatric emergencies. *Postgraduate Medicine* 58:87-93, 1975. 4. Birkett DP, Hirschfield W, Simpson GM. Thiothixene in the treatment of diseases of the senium. *Curr Ther Res* 14:775-779, 1972. 5. Data on file at Roerig.

BRIEF SUMMARY OF PRESCRIBING INFORMATION
Navane® (thiothixene) Capsules: 1 mg, 2 mg, 5 mg, 10 mg, 20 mg
(thiothixene hydrochloride) Concentrate: 5 mg/ml, Intramuscular: 2 mg/ml, 5 mg/ml

Contraindications: Navane (thiothixene) is contraindicated in patients with circulatory collapse, comatose states, central nervous system depression due to any cause, and blood dyscrasias Navane is contraindicated in individuals who have shown hypersensitivity to the drug It is not known whether there is a cross-sensitivity between the thioxanthenes and the phenothiazine derivatives, but the possibility should be considered

Warnings: *Usage in Pregnancy*—Safe use of Navane during pregnancy has not been established Therefore, this drug should be given to pregnant patients only when, in the judgment of the physician, the expected benefits from the treatment exceed the possible risks to mother and fetus. Animal reproduction studies and clinical experience to date have not demonstrated any teratogenic effects.

In the animal reproduction studies with Navane, there was some decrease in conception rate and litter size, and an increase in resorption rate in rats and rabbits, changes which have been similarly reported with other psychotropic agents After repeated oral administration of Navane to rats (5 to 15 mg/kg/day), rabbits (3 to 50 mg/kg/day), and monkeys (1 to 3 mg/kg/day) before and during gestation, no teratogenic effects were seen. (See Precautions.)

Usage in Children—The use of Navane in children under 12 years of age is not recommended because safety and efficacy in the pediatric age group have not been established

As is true with many CNS drugs, Navane may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery, especially during the first few days of therapy Therefore, the patient should be cautioned accordingly

As in the case of other CNS-acting drugs, patients receiving Navane should be cautioned about the possible additive effects (which may include hypotension) with CNS depressants and with alcohol.

Precautions: An antiemetic effect was observed in animal studies with Navane, since this effect may also occur in man, it is possible that Navane may mask signs of overdosage of toxic drugs and may obscure conditions such as intestinal obstruction and brain tumor.

In consideration of the known capability of Navane and certain other psychotropic drugs to precipitate convulsions, extreme caution should be used in patients with a history of convulsive disorders or those in a state of alcohol withdrawal since it may lower the convulsive threshold. Although Navane potentiates the actions of the barbiturates, the dosage of the anticonvulsant therapy should not be reduced when Navane is administered concurrently.

Caution as well as careful adjustment of the dosage is indicated when Navane is used in conjunction with other CNS depressants other than anticonvulsant drugs.

Though exhibiting rather weak anticholinergic properties, Navane should be used with caution in patients who are known or suspected to have glaucoma, or who might be exposed to extreme heat, or who are receiving atropine or related drugs

Use with caution in patients with cardiovascular disease.

Also, careful observation should be made for pigmentary retinopathy, and lenticular pigmentation (fine lenticular pigmentation has been noted in a small number of patients treated with Navane for prolonged periods). Blood dyscrasias (agranulocytosis, pancytopenia, thrombocytopenic purpura), and liver damage (jaundice, biliary stasis) have been reported with related drugs.

Undue exposure to sunlight should be avoided Photosensitive reactions have been reported in patients on Navane

Neuroleptic drugs elevate prolactin levels; the elevation persists during chronic administration. Tissue culture experiments indicate that approximately one-third of human breast cancers are prolactin dependent *in vitro*, a factor of potential importance if the prescription of these drugs is contemplated in a patient with a previously detected breast cancer Although disturbances such as galactorrhea, amenorrhea, gynecomastia, and impotence have been reported, the clinical significance of elevated serum prolactin levels is unknown for most patients. An increase in mammary neoplasms has been found in rodents after chronic administration of neuroleptic drugs. Neither clinical studies nor epidemiologic studies conducted to date, however, have shown an association between chronic administration of these drugs and mammary tumorigenesis, the available evidence is considered too limited to be conclusive at this time.

Intramuscular Administration—As with all intramuscular preparations, Navane Intramuscular should be injected well within the body of a relatively large muscle. The preferred sites are the upper outer quadrant of the buttock (i.e. gluteus maximus) and the mid-lateral thigh.

The deltoid area should be used only if well developed, such as in certain adults and older children, and then only with caution to avoid radial nerve injury Intramuscular injections should not be made into the lower and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel

Adverse Reactions: *Note*: Not all of the following adverse reactions have been reported with Navane (thiothixene). However, since Navane has certain chemical and pharmacologic similarities to the phenothiazines, all of the known side effects and toxicity associated with phenothiazine therapy should be borne in mind when Navane is used

Cardiovascular effects. Tachycardia, hypotension, lightheadedness, and syncope. In the event hypotension occurs, epinephrine should not be used as a pressor agent since a paradoxical further lowering of blood pressure may result. Nonspecific EKG changes have been observed in some patients receiving Navane. These changes are usually reversible and frequently disappear on continued Navane therapy. The incidence of these changes is lower than that observed with some phenothiazines. The clinical significance of these changes is not known.

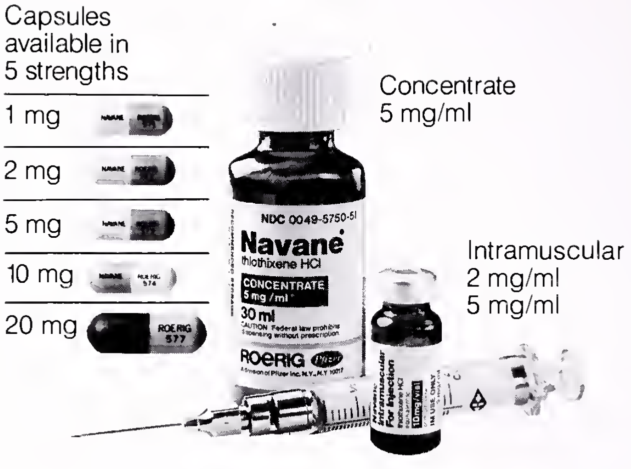
CNS effects: Drowsiness, usually mild, may occur although it usually subsides wtih continuation of Navane therapy The incidence of sedation appears similar to that of the piperazine group of phenothiazines, but less than that of certain aliphatic phenothiazines Restlessness, agitation and insomnia have been noted with Navane (thiothixene) Seizures and paradoxical exacerbation of psychotic symptoms have occurred with Navane infrequently.

Hyperreflexia has been reported in infants delivered from mothers having received structurally related drugs

In addition, phenothiazine derivatives have been associated with cerebral edema and cerebrospinal fluid abnormalities

Extrapyramidal symptoms, such as pseudo-parkinsonism, akathisia, and dystonia have been reported Management of these extrapyramidal symptoms depends upon the type and severity Rapid relief of acute symptoms may require the use of an injectable antiparkinson agent. More slowly emerging symptoms may be managed by reducing the dosage of Navane and/or administering an oral antiparkinson agent.

Persistent Tardive Dyskinesia: As with all antipsychotic agents tardive dyskinesia may appear in some patients on long term therapy or may occur after drug therapy has been discontinued. The risk seems to be greater in elderly patients on high-dose therapy, especially females. The symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Sometimes these may be accompanied by involuntary movements of extremities.



There is no known effective treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms of this syndrome. It is suggested that all antipsychotic agents be discontinued if these symptoms appear.

Should it be necessary to reinstitute treatment, or increase the dosage of the agent, or switch to a different antipsychotic agent, the syndrome may be masked

It has been reported that fine vermicular movements of the tongue may be an early sign of the syndrome and if the medication is stopped at that time, the syndrome may not develop.

Hepatic effects: Elevations of serum transaminase and alkaline phosphatase, usually transient, have been infrequently observed in some patients. No clinically confirmed cases of jaundice attributable to Navane (thiothixene) have been reported.

Hematologic effects: As is true with certain other psychotropic drugs, leukopenia and leukocytosis, which are usually transient, can occur occasionally with Navane. Other antipsychotic drugs have been associated with agranulocytosis, eosinophilia, hemolytic anemia, thrombocytopenia and pancytopenia

Allergic reactions: Rash, pruritus, urticaria, photosensitivity and rare cases of anaphylaxis have been reported with Navane. Undue exposure to sunlight should be avoided. Although not experienced with Navane, exfoliative dermatitis and contact dermatitis (in nursing personnel) have been reported with certain phenothiazines

Endocrine disorders: Lactation, moderate breast enlargement and amenorrhea have occurred in a small percentage of females receiving Navane. If persistent, this may necessitate a reduction in dosage or the discontinuation of therapy Phenothiazines have been associated with false positive pregnancy tests, gynecomastia, hypoglycemia, hyperglycemia, and glycosuria.

Autonomic effects: Dry mouth, blurred vision, nasal congestion, constipation, increased sweating, increased salivation, and impotence have occurred infrequently with Navane therapy. Phenothiazines have been associated with miosis, mydriasis, and adynamic ileus.

Other adverse reactions: Hyperpyrexia, anorexia, nausea, vomiting, diarrhea, increase in appetite and weight, weakness or fatigue, polydipsia and peripheral edema.

Although not reported with Navane, evidence indicates there is a relationship between phenothiazine therapy and the occurrence of a systemic lupus erythematosus-like syndrome.

NOTE: Sudden deaths have occasionally been reported in patients who have received certain phenothiazine derivatives. In some cases the cause of death was apparently cardiac arrest or asphyxia due to failure of the cough reflex In others, the cause could not be determined nor could it be established that death was due to phenothiazine administration.

Dosage and Administration: Dosage of Navane should be individually adjusted depending on the chronicity and severity of the condition. In general, small doses should be used initially and gradually increased to the optimal effective level, based on patient response.

Some patients have been successfully maintained on once-a-day Navane therapy.

Usage in children under 12 years of age is not recommended because safe conditions for its use have not been established

Navane Intramuscular Solution: Navane For Injection—Where more rapid control and treatment of acute behavior is desirable, the intramuscular form of Navane may be indicated. It is also of benefit where the very nature of the patient's symptomatology, whether acute or chronic, renders oral administration impractical or even impossible.

For treatment of acute symptomatology or in patients unable or unwilling to take oral medication, the usual dose is 4 mg of Navane Intramuscular administered 2 to 4 times daily. Dosage may be increased or decreased depending on response. Most patients are controlled on a total daily dosage of 16 to 20 mg The maximum recommended dosage is 30 mg/day An oral form should supplant the injectable form as soon as possible. It may be necessary to adjust the dosage when changing from the intramuscular to oral dosage forms. Dosage recommendations for Navane (thiothixene) Capsules and Concentrate appear in the following paragraphs.

Navane Capsules: Navane Concentrate—In milder conditions, an initial dose of 2 mg three times daily. If indicated, a subsequent increase to 15 mg/day total daily dose is often effective.

In more severe conditions, an initial dose of 5 mg twice daily.

The usual optimal dose is 20 to 30 mg daily. If indicated, an increase to 60 mg/day total daily dose is often effective Exceeding a total daily dose of 60 mg rarely increases the beneficial response.

Overdosage: Manifestations include muscular twitching, drowsiness, and dizziness. Symptoms of gross overdosage may include CNS depression, rigidity, weakness, torticollis, tremor, salivation, dysphagia, hypotension, disturbances of gait, or coma.

Treatment: Essentially is symptomatic and supportive. For Navane oral, early gastric lavage is helpful. For Navane oral and Intramuscular, keep patient under careful observation and maintain an open airway, since involvement of the extrapyramidal system may produce dysphagia and respiratory difficulty in severe overdosage. If hypotension occurs, the standard measures for managing circulatory shock should be used (I.V. fluids and/or vasoconstrictors.)

If a vasoconstrictor is needed, levarterenol and phenylephrine are the most suitable drugs. Other pressor agents, including epinephrine, are not recommended, since phenothiazine derivatives may reverse the usual pressor action of these agents and cause further lowering of the blood pressure.

If CNS depression is present and specific therapy is indicated, recommended stimulants include amphetamine, dextroamphetamine, or caffeine and sodium benzoate. Stimulants that may cause convulsions (e.g picrotoxin or pentylenetetrazol) should be avoided Extrapyramidal symptoms may be treated with antiparkinson drugs.

There are no data on the use of peritoneal or hemodialysis, but they are known to be of little value in phenothiazine intoxication.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals

By Ray E. Helfer, MD

What physicians need to do about child abuse

The recent increase of activity by organized medicine in the problems of child abuse and neglect comes at a most opportune time. Federal and state government interest is waning, and yet the plight of these chlidren and their families is worsening.

Physicians' know-how, administrative capabilities, lobbying efforts and large organizations and their infuence are refreshing and provide much-needed relief.

The "news from the front" is both good and bad. On the good side, Michigan (thanks to the extreme pressure applied by many, including MSMS) is about to replace the 100 protective service workers cut two years ago. Our state recently passed the Children's Trust Fund to provide a source of funds for prevention programs.

The bad news is we are not making much progress in fighting the battles of family violence and the devastating effect this method of "resolving" interpersonal problems has upon our children.

The purpose of this review is to share some of the past and present in a manner that will encourage action. Problems are stated and actions proposed for resolution. They are by no means all-inclusive, but rather, are a beginning. We hope they are stated with sufficient emphasis and importance to encourage MSMS, the county societies and individual members to remain involved for years to come.

To place the eight situations discussed below into perspective, child abuse and neglect should be viewed as a breakdown in the interpersonal interactions between two parties who mean a great deal to each other, parents and their children. The definition that is most workable to delineate this breakdown is:

Child abuse and neglect is any interaction or lack of interaction between a child and his/her caregiver which results in non-accidental harm to the child's physical and/or developmental state.

With this brief introduction, the next step is to consider several situations in Michigan that need immediate attention and action by MSMS, local societies and individual members.

Problem

Each year in Michigan, almost 40,000 cases of suspected child abuse and neglect are reported to the Department of Social Services. This represents more than one percent of all Michigan children, 17 years old and less. Slightly less than 50 percent of these cases meet the DSS criteria for taking action. This number is alarmingly small, in light of the current level of knowledge in our state regarding the problem. Even more disturbing, the criteria are very difficult to delineate.

Action needed

A careful study must be undertaken to follow up on a large, randomly selected sample of the cases acted upon to determine the validity of this decision. Only then can criteria be developed to be used for these difficult decisions.

Problem

In 1975 the State of Michigan revised its child abuse and neglect reporting law. Section 9 of this law reads (in part), "The Department . . . shall provide . . . multidisciplinary services such as those of a pediatrician, psychologist, psychiatrist, public health nurse, social worker, or attorney through the establishment of regionally based or strategically located teams."

The Department has never implemented this section of the law. In all fairness, the legislation has never given funds for its implementation, but the Department has never included a request for these funds in its annual budget.

Action needed

The Department must be forced to implement this law and develop regional diagnostic centers. To force this issue a class-action lawsuit, on behalf of abused children and their families, may be necessary. This could be brought by any number of groups on behalf of our children. Should MSMS take the lead?

Problem

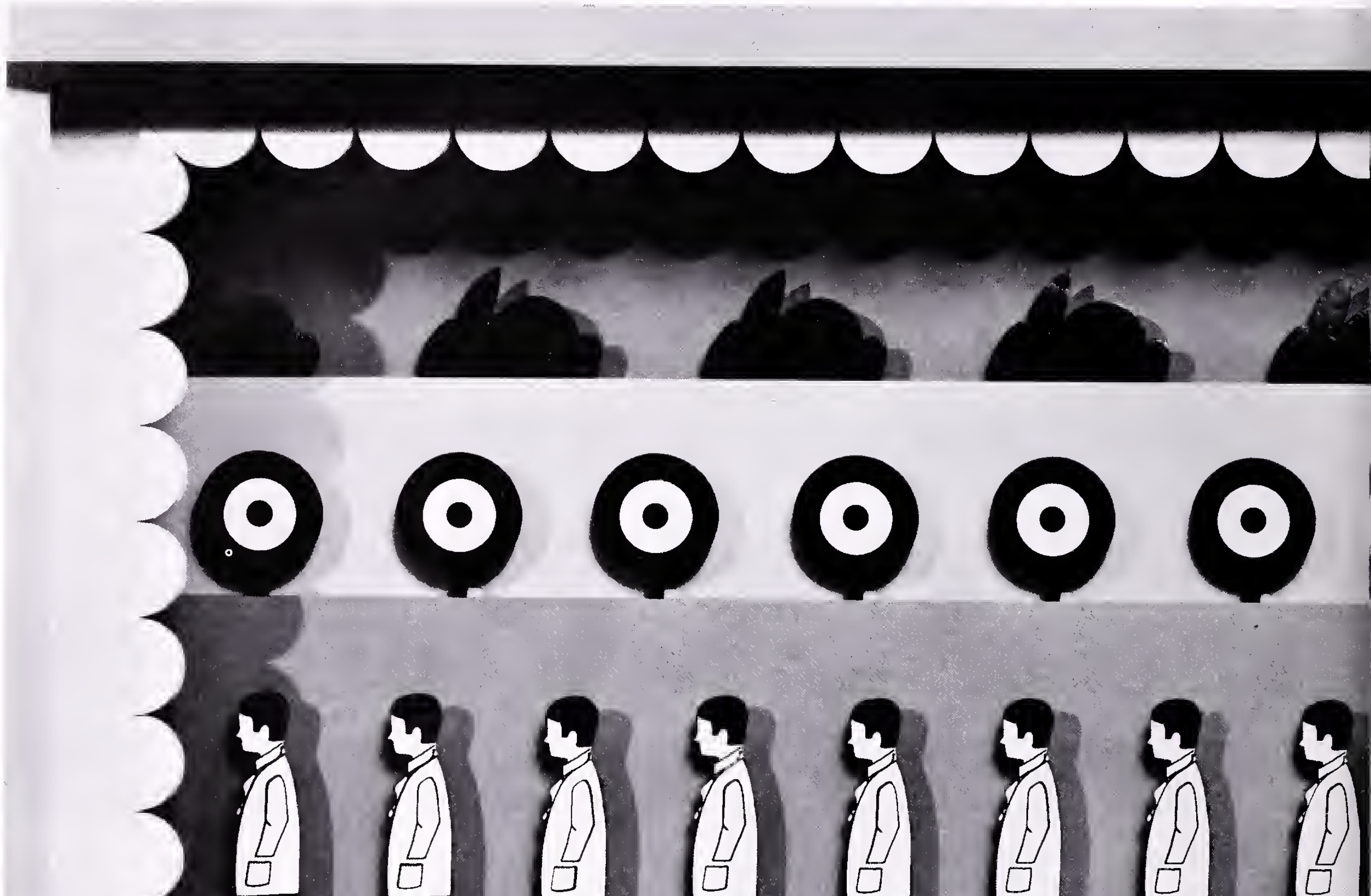
A child learns how interpersonal problems are solved by two people who mean a great deal to each other through observing a mother and father settle their disagreements and handling disputes with their children. Positive modeling during these very impressionistic developmental years is critical.

The long-term outcome of being reared in an abusive, neglectful, and/or incestuous home is that by late adolescence the children emerge with extremely

Continued on page 72

Doctor Helfer is professor, Department of Pediatrics and Human Development, Michigan State University. He is a member of the MSMS Committee on Child Abuse and Neglect.

If you become the target of a



©1983 MPMLC

professional liability claim...

You will be glad you have Michigan Physicians.

Michigan Physicians has been solving complex medical professional liability problems since 1976. With the state's largest and most experienced claims staff, Michigan Physicians works with you to resolve claims (and incidents) that most physicians have never faced in their careers.

In a changing legal environment, you need the best coverage you can buy because the risk of a professional liability claim is becoming greater every day.

For a confidential rate quotation and more information about Michigan's leading physician-owned insurance company, call or write the office in your area.

Michigan Physicians
Mutual Liability Company

1305 Abbott Road
East Lansing, MI 48823
(517) 351-1150
(800) 292-1926

6735 Telegraph Road
Suite 205
Birmingham, MI 48010
(313) 647-5550

Endorsed by the Michigan State Medical Society

Health Legislation Update

The following legislative update as of December, 1983, was prepared by the MSMS government relations staff. Where MSMS has taken a stand on a bill, that stand is printed in boldface type. For further details, please contact Kevin Kelly or Bruce Ambrose at MSMS headquarters.

House Bill 4084
Medicaid Abortions
(Same as Senate Bill 136)
Sponsor: Representative Mike Griffin (D-Jackson)
Status: Passed by both Houses, vetoed by the governor. The veto has been overridden in the Senate, the attempt to override the governor's veto awaits action on the House floor.

This bill would prohibit state funding of Medicaid abortions unless the abortion is necessary to save the life of the mother.

House Bill 4087
Weight Loss Clinics
Sponsor: Representative Burton Leland (D-Detroit)
Status: Referred to Committee on Public Health

HB 4087 would require registration and oversight by the Department of Public Health of certain weight loss clinics.

MSMS Position: MSMS supports this legislation.

House Bill 4090
Cancer Registry
Sponsor: Representative Francis Spaniola (D-Corunna)
Status: Introduced 2/2/83. House Committee on Public Health. Reported out 9/20/83. Passed the House 9/28/83. Senate Committee on Health and Social Services.

The bill requires the Department of Public Health to set up a statewide cancer registry, recording information that would be helpful in epidemiologic surveys of cancer and related diseases.

House Bill 4167
Surgical Clinics
Sponsor: Representative James Dressel (R-Holland)
Status: Referred to House Committee on Taxation

Section 7r of the property tax act exempts real estate and buildings operated by nonprofit corporations with funds derived solely from payments and contributions under the terms of collective bargaining agreements between employers and representatives of employees for whose use the clinic is maintained. The real estate with the buildings and other property located on the real estate on that acreage, owned and occupied by a nonprofit trust and used for hospital or public health purposes is exempt from taxation except:

"THE REAL ESTATE AND BUILDINGS OF A FREESTANDING SURGICAL OUTPATIENT FACILITY EVEN THOUGH OWNED AND OPERATED BY AN EXEMPT HOSPITAL."

House Bill 4203
Mandatory Seat Belts

Sponsor: Representative Dave Hollister (D-Lansing)

Status: House Insurance Committee

HB 4203 will amend the Michigan vehicle code to require seat belt use by the driver and front-seat passengers of an automobile. A violation of this proposed legislation would be considered a civil offense punishable by a fine of no more than $10.

MSMS Position: MSMS supports this legislation.

House Bill 4708
Parental Consent

Sponsor: Representative Alma Stallworth (D-Detroit)

Status: Passed the House 11/17/83. Referred to the Senate Committee on Health and Social Services.

This bill waives necessity of parental consent for minors to obtain prenatal and pregnancy-related medical services. The consent of the minor would be sufficient to obtain physician care for the minor or for the minor's child.

MSMS Position: MSMS supports this legislation.

House Bill 4735
Hospital Capital Expenditure Limitations

Sponsor: Representative Sandy Brotherton (R-Farmington)

Status: Referred to the House Committee on Public Health. Preliminary hearings have been held by a health care cost containment subcommittee of the House Public Health Committee. The subcommittee is chaired by Representative Jeff Padden.

HB 4735 establishes a process for setting statewide, annual limits on hospital capital expenditures. HB 4735 limits all hospital capital expenditures in any year to 115 percent of the previous five years' average.

House Bill 4782
State Boards Immunity

Sponsor: Representative James O'Neill (D-Saginaw)

Status: Referred to House Judiciary Committee

HB 4782 would provide immunity against legal action for members of State Boards and Agencies

MSMS Position: MSMS supports HB 4782

House Bills 4798, 4799, 4800, 4801, 5067, 5068
Prudent Purchaser Agreements

Sponsor: Representative Matthew McNeely (D-Detroit)

Status: Passed House 11/16/83. Referred to Senate Committee on Commerce.

The PPA package to date consists of the following bills: HB 4798, which enables the formation of PPAs by commercial insurers; HB 4799-4801, which enables the formation of PPAs by Blue Cross Blue Shield of Michigan; HB 5068, which enables the formation of PPAs by Delta Dental Plan; HB 5069, the "Prudent Purchaser Act," which primarily governs the agreements between "prudent purchasers" and providers.

The legislation authorizes the development of two types of coverage; exclusive provider coverage and preferred provider coverage. Exclusive provider coverage requires a policyholder to receive services from a provider on the panel as a condition of having the service covered. Preferred provider coverage will cover services delivered by a provider who is not on the provider panel, but will include financial or benefit incentives to encourage policyholders to receive services from providers on the panel.

Individuals who are offered either exclusive or preferred provider coverage also must be offered the option of standard insurance coverage. If a *group of more than 25 employees* enters into a contract for exclusive provider coverage, each member of the group must be offered a choice between exclusive and preferred provider coverage. These provisions were included in the legislation to insure that PPAs do not unduly restrict an individual's free choice of a health care provider.

There is still concern that the financial incentives offered to employees may be so coercive that a realistic "dual choice" may be nullified.

HB 5069, the "Prudent Purchaser Act," outlines the obligations and responsibilities of organizations ("Organization" means an insurer, a dental care corporation, hospital service corporation, medical care corporation, health care corporation, or third party administrator) that

Continued on next page

enter into prudent purchaser arrangements. H.B. 5069:

1. Permits organizations (primarily insurers) to enter into agreements with health care providers (individuals, facilities, HMOs, centers, clinics, treatment programs, and institutions) who presumably would offer appropriate and quality care to their members at competitive prices.

2. Permits insurers to limit the number of PPAs so long as reasonable access to care is assured for subscribers. The insurer determines what is reasonable.

3. Coins the phrase "provider panels" to describe the providers who enroll in PPAs.

4. Requires insurers to give health care providers a reasonable opportunity to apply for membership on panels.

5. Requires insurers to file with the insurance commissioner written standards on which PPAs will be based. The standards must be based on maintaining quality care, controlling costs, assuring appropriate utilization of services, assuring reasonable levels of access to services, and others deemed appropriate by the insurer.

6. Each agreement must state that a provider may be removed for non-compliance with the contract requirements.

7. Requires insurers to notify providers of the formation of PPAs and to provide written standards.

8. Requires insurers to assure professional review of the quality of health care, performance of health care personnel, and utilization of services and facilities.

9. Prohibits an insurer from discriminating between classes of providers legally entitled to provide the same health care services.

10. Requires insurers to report to the insurance commissioner various information about their PPAs.

11. Protects confidential information regarding patient care.

12. Requires insurers to maintain PPA financial records separate from the records of its other operations.

13. Permits providers to enter into joint agreements to sell health care service packages.

14. Sunsets the legislation five years from when it takes effect.

MSMS Position: On September 14, the MSMS Board of Directors established the following MSMS policy on Preferred Provider Legislation:

1. That preferred provider legislation in Michigan should permit utmost flexibility to allow for innovation in PPO systems, and should encourage and nourish new organizations by health care professionals.

2. That most specific standards should be developed with physician input and advice to assure that quality of medical care and access to medical care are goals equivalent to cost containment.

3. That all provider-sponsored PPOs should be exempted from regulations imposed on third party administered PPOs.

4. That all PPO business done by BCBSM and health insurers should be separate and isolated from traditional lines of health insurance.

5. That all PPOs must be required to have independent outside physician peer review to assure quality care.

House Bill 4811
Patient's Consent

Sponsor: Representative Sandy Brotherton (R-Farmington)

Status: Referred to House Committee on Public Health

HB 4811 would prohibit a physician from administering or ordering tests for a patient unless he or she obtains the patient's signed consent to the tests on a form that clearly describes each test and states the total cost of each test.

MSMS Position: MSMS is opposed to HB 4811.

House Bill 4857
Optometry Scope

Sponsor: Representative Mike Griffin (D-Jackson)

Status: Referred to House Committee on Public Health

The bill limits the scope of practice of optometrists by specifically restricting use of drugs and prohibiting any treatment or diagnosis other than those activities set forth in the current law. Requires optometrists to refer patients with certain conditions to ophthalmologists.

House Bill 4941
Lay Midwifery

Sponsor: Representative Mike Hayes (R-Midland)

Status: Referred to Committee on Public Health

The bill establishes the Michigan Board of Lay Midwifery and

Continued on page 70

ELECTIONS '84

In the upcoming 1984
elections Michigan
voters will elect
a U.S. Senator,
18 Congressmen and
110 State
Representatives

MDPAC

MDPAC

MICHIGAN DOCTORS POLITICAL ACTION COMMITTEE

MDPAC *needs* your financial support in order to contribute to the campaigns of candidates responsive to the concerns of the medical profession. It is in the political arena that the major decisions affecting the medical profession are being made. Make a professional membership investment in

MDPAC

An MDPAC investment:

- Reflects physician commitment to political action and results
- Represents a large physician "precinct" motivated to influence the political and legislative processes that affect the practice of medicine
- Provides a coordinated means for medicine to support candidates who recognize and promote the aims of the medical profession

MDPAC Regular Membership	$ 50.00
MDPAC Sustaining Membership	$150.00

(All sustainers receive an MDPAC sustainer pin.)

MDPAC contributions should be written
on a personal check

MDPAC, P.O. Box 769, East Lansing, MI 48823

To Learn the Latest in the Recognition, Diagnosis & Treatment of Athletic Injuries

Plan Now to Attend the

1984 MSMS

CONFERENCE ON SPORTS MEDICINE

to be held

Thursday, April 12

at

LONG'S CONVENTION CENTER

LANSING

Earn Category I CME Credit; hear expert guest clinicians;
meet fellow physicians, coaches and trainers.

provides guidelines for the registration and practice of lay midwives.

MSMS Position: MSMS opposed HB 4941.

House Bill 4949
Optometry Scope

Sponsor: Representative Richard Fitzpatrick (D-Battle Creek)

Status: Referred to House Committee on Public Health

The bill expands the scope of practice for optometrists by permitting them to administer certain diagnostic drugs. The Board of Optometry certifies those optometrists qualified to administer diagnostic drugs.

House Bill 5007
Medicaid Reimbursement

Sponsor: Representative Sandy Brotherton (R-Farmington)

Status: Referred to House Committee on Social Services and Youth

This bill limits Medicaid hospital reimbursement to the hospital's customary per diem bed cost or the average per diem bed cost for the health care service area, whichever is lower.

House Bill 5010
Controlled Substances

Sponsor: Representative John Cherry (D-Flint)

Status: Referred to House Committee on Public Health

The bill moves the drugs amphetamines and methaqualones to the most restrictive classification of controlled substances. The drugs currently are on Schedule 2, which permits their medical use. It also intends to limit the dispensing of Schedule 5 drugs to those for which there are prescriptions.

MSMS Position: MSMS is opposed to HB 5010.

House Bill 5098
Board Sanctions

Sponsor: Representative Sandy Brotherton (R-Farmington)

Status: Referred to House Committee on Public Health

This bill prohibits an agency or court from granting a stay of the enforcement of a sanction imposed by the Board of Medicine or the Board of Osteopathic Medicine and Surgery on its licensees.

House Bill 5102
False Claims

Sponsor: Representative Jeff Padden (D-Wyandotte)

Status: Referred to the House Committee on Judiciary

This bill broadens the definition of false Medicaid claims, provides that standard billing procedures, such as computer billings, are prima facie evidence of knowledge of claims, and permits the attorney general to make ex parte petitions to the circuit court for subpoenaing records involved in a Medicaid fraud investigation.

House Bill 5103
Health Care Fraud

Sponsor: Representative Jeff Padden (D-Wyandotte)

Status: Referred to House Judiciary Committee

HB 5103 creates a new statute (the health care false claim act) spelling out penalties for fraudulent health care billings.

Senate Bill 63
Surrogate Parenting

Sponsor: Senator Connie Binsfeld (R-Maple City)

Status: Passed Senate on 11/15/83. Referred to House Judiciary Committee.

SB 63 prohibits surrogate parenting arrangements and the subsequent relinquishing of parental rights.

Senate Bill 224
Medical Malpractice

Sponsor: Senator Pat McCollough (D-Dearborn)

Status: Referred to Senate Judiciary Committee

The bill places limits on the noneconomic damages recoverable by plaintiffs, admits evidence of collateral payments to plaintiffs, specifies qualifications of witnesses, redefines medical malpractice, permits periodic payments of judgments, and limits the liability of individuals in a group.

MSMS Position: MSMS supports SB 224.

Senate Bill 336
Chiropractic Scope

Sponsor: Senator Jack Faxon (D-Southfield)

Status: Referred to Senate Committee on Health and Social Services

SB 336 expands the scope of practice for chiropractic by permitting use of physical therapy, X-rays for the full skeletal system, and nutritional supplements. Identical to HB 4366.

MSMS Position: MSMS opposes SB 336.

Senate Bills 440, 441, 442
BCBSM Mutual

Sponsor: Senator Robert Welborn (R-Kalamazoo)

Status: Referred to Senate Committee on Commerce

This set of bills permits the conversion of Blue Cross Blue Shield to a mutual life and disability insurer.

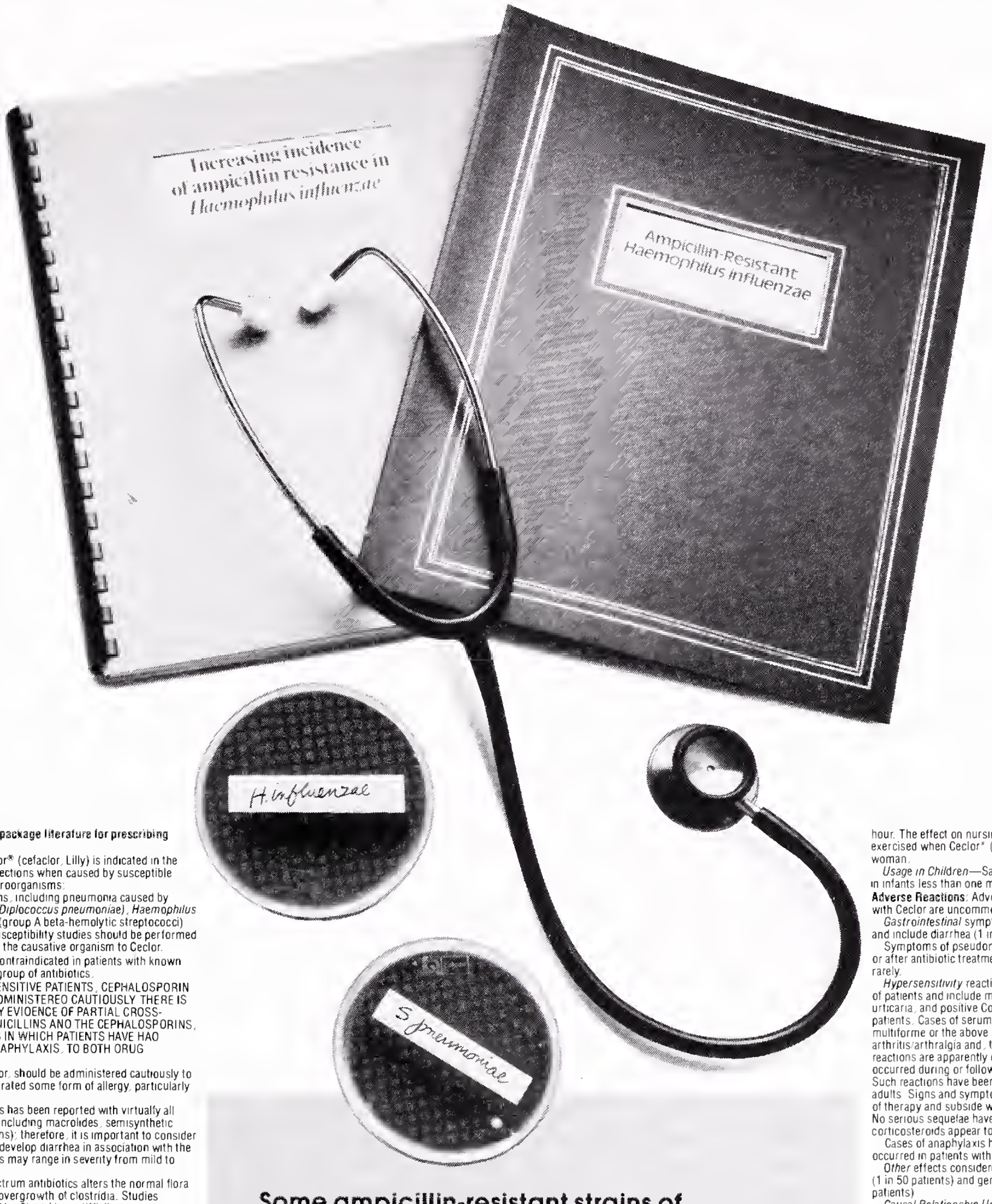
Senate Bill 531
Clinical Labs

Sponsor: Senator Joe Conroy (D-Flint)

Status: Referred to the Senate Committee on Health and Social Services

This bill requires disclosure by physicians of financial interests in clinical labs, creates professional review entities under the jurisdiction of licensing boards, creates a Health Services Utilization Study Council on the governor's office to study and develop a profile of clinical lab business in the state, funds the council from assessments on physicians, and establishes disciplinary actions for noncompliance.

An added complication... in the treatment of bacterial bronchitis*


Increasing incidence of ampicillin resistance in *Haemophilus influenzae*
Ampicillin-Resistant Haemophilus influenzae
H. influenzae
S. pneumoniae

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively Trace amounts were detected at one hour. The effect on nursing infants is not known Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200)

[061782R]

---

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information.

References

1. Antimicrob Agents Chemother., *8* 91, 1975
2. Antimicrob. Agents Chemother., *11*. 470, 1977
3. Antimicrob Agents Chemother., *13* 584, 1978
4. Antimicrob Agents Chemother., *12* 490, 1977.
5. Current Chemotherapy (edited by W Siegenthaler and R Luthy), II 880 Washington, D.C. American Society for Microbiology, 1978
6. Antimicrob Agents Chemother., *13* 861, 1978
7. Data on file, Eli Lilly and Company
8. Principles and Practice of Infectious Diseases (edited by G L Mandell, R.G Douglas, Jr., and J E Bennett), p 487 New York John Wiley & Sons, 1979

© 1982, ELI LILLY AND COMPANY

Lilly

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

300035

limited skills of developing and maintaining close interpersonal relationships, especially with peers and their own children.

Violence teaches them a most peculiar and pathologic form of interpersonal problem solving. Not all these children enter adulthood with the same degree of limitations, however. Those who escape these serious limitations *seem* to have been spared, in part, by a mentor they found along the way, a coach, teacher, aunt or doctor.

Action needed

To make available for these children long-term mentor relationships which say, "when you are with me you're safe" and "when you're with me, you're special." The schools have a primary responsibility in this area.

Problem

The mortality rate from abuse and neglect in Michigan (at least 50 per year) is harder to determine than the overall incidence.

The problem is two-fold, with both parts lying in the Office of the Medical Examiners of our counties. Skills are sometimes not sufficient to detect the cause of death. Separating SIDS, e.g., from intentional suffocation is a task that is sometimes impossible to achieve. An area that can be resolved, however, is the reluctance some examiners have to "take a stand." Some are content to label only the cause of death and not the circumstances.

Action needed

These problems could be attacked if we had regional medical examiners with special skills in this field. We have consultants at the regional level for cardiology and surgery, so why not for assessing the cause of death in children? Likewise, medical examiners must be forced to report cases of suspected abuse and neglect (the law requires this, but no action is taken when they do not). Finally, a state-level medical examiner's office would be most welcome. Your support of this proposed legislation would be most helpful.

Problem

The State Attorney General's Office does not have one attorney whose job it is to handle or be expert in issues relating to family law. Attorney General Kelley has not (and does not) plan any such division.

Action needed

There is urgent need to establish a family law section in the Attorney General's Office. This section should advise the legislature, department administrators, and county prosecutors on issues relating to family violence and other legal matters involving family interaction.

Problem

For those childen who survive abuse, neglect and sexual exploitation without death or permanent physical damage, as most do, the scars that remain are imprinted upon their developmental state (note definition). From their delayed language and learning disorders to their decreased skills of developing and maintaining long-term close personal relationships, these young people are permanently scarred.

What then is the prevalence of this social malady, i.e., the frequency in which this problem is found in our population?

If one were to survey every 18 year old child in this state as to his/her experiences as a growing and developing child, one would find (assuming the national statistics hold true in Michigan):

(1) Approximately 20 percent experienced some form of family violence.

(2) Approximately six percent of the males experienced some form of incest.

(3) Approximately 15 percent of the females experienced some form of incest.

Action needed

Earlier intervention, i.e., prevention programs directed toward children and young adults whose development has been warped by these early childhood experiences.

Problem

The more that is learned about child abuse, neglect and sexual exploitation, the more apparent it becomes that the manner in which these problem children present to physicians varies greatly.

What are *some* of these unusual forms of presentation (some of which may not be so unusual)?

Several can be listed:

(1) GU complaints, abdominal pain, and/or headache in small children who are sexually molested.

(2) School absenteeism in children who fear leaving home where they must remain because of a bruise, to "protect" their mother, etc.

(3) An adolescent pregnancy, not from sexual interaction with a peer, rather from incest about which the girl is afraid to talk.

(4) A failure-to-thrive infant in a seemingly "well adjusted" family.

(5) An abused spouse from a "stable" middle class, God-fearing family.

(6) Unexplained trauma

Action needed

Be alert! Insist that your community or region has an assessment diagnostic team (see Dr. Lucas' article page 53) with whom you can consult in these difficult cases.

Problem

Sometimes a case of abuse and/or neglect is repeated, or some other injustice occurs, and you just cannot get anywhere with the "system."

What is the next step?

Action needed

Write or call your county director of social services, police chief, probate judge and/or prosecuting attorney. The local state police post is often helpful.

The AMA puts current information at your fingertips.

The first nationwide medical information network brings a new dimension to the way in which physicians and other health care professionals keep abreast of the latest knowledge in their profession.

Now, through the use of a low-cost computer terminal or personal computer, you can have instant access to authoritative and up-to-date information. The American Medical Association's computerized data bases place a wide range of professional resources at your fingertips, such as clinical, administrative, medical practice information, and abstracts of current clinical literature. Physicians can earn Category I, Continuing Medical Education (CME) credit using the Massachusetts General Hospital Continuing Medical Education programs or can elect to use the MGH-CME programs as informational updates or refresher courses.

Adding a new dimension to the way in which you communicate is MED/MAIL electronic mail. With the same terminal, you can send messages to your colleagues across the country or across the city . . . in minutes.

Information that could take hours to acquire through traditional channels can now be gathered in minutes, giving you valuable extra time for other important activities. And you can use the medical information network at your convenience, 24 hours a day, from your office, hospital or home.

It's surprisingly economical and professionally indispensable.

GTE Telenet

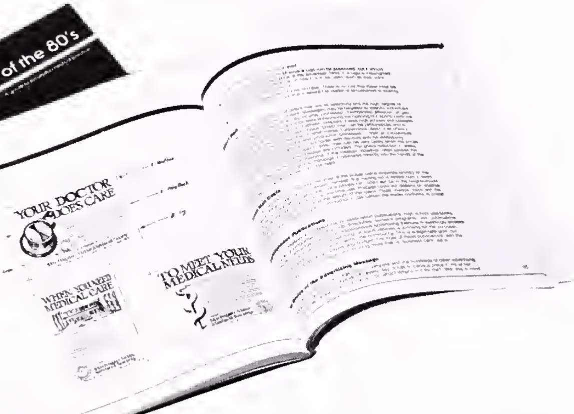
Medical Information Network

FOR SUBSCRIPTION INFORMATION PLEASE CONTACT
PHYSICIAN SERVICE GROUP, INC.
A member service subsidiary of the
MICHIGAN STATE MEDICAL SOCIETY
EAST LANSING, MICHIGAN

Ellen Vinocur Potash
Telephone 517/337-1351

GTE

Be wise about the 80s



Send $5 per copy to Mert Scholten, MSMS, Box 950, East Lansing, MI 48823.

Order your copy of this book!

All doubting Thomases take note: no more graphic proof of the growth and transformation of American medicine could be found than that in the communications chapter of the MSMS Book "Challenge of the 80s: A guide to successful medical practice."

Fifteen years ago, who would have thought that MSMS would provide instructions to physicians on how to use the media for advertising? This section is practical, even provides cost information and gives enough information to permit the physician to design a simple ad and decide when to run it. This really amounts to an outstanding 16-page primer on the basics of advertising — something virtually no physician is likely to have ever read before.

The communications chapter also concentrates on recommendations for improvements in the more conventional ways of developing a physician's reputation, for those not ready to run an ad in the local newspaper.

The physician is taught how to show his or her interest in and consideration of the patient, how office reception areas and personnel may affect the patient's perception of the doctor's care, how to elicit or actually survey patients for feedback on their reactions to their care, how to develop good working relationships with referring doctors, and how to exhibit effective teamwork in the hospital setting.

A surprising number of concrete, specific, and practical suggestions may be found here, many of which will be new to readers.

Times are certainly changing. Those who do not wish to be left behind should read "Challenge of the 80s: A guide to successful medical practice," if they want to learn how to change along with the times.

Susan J. Adelman, MD, President
Wayne County Medical Society

References:
1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris *Am Heart J* 104 672-681, September 1982.
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm: Experience in 127 patients *N Engl J Med* 302:1269-1273, June 5, 1980

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. **Vasospastic Angina**: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine or 3) angiographically demonstrated coronary artery spasm In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e g where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and or adequate doses of beta blockers.

II. **Chronic Stable Angina (Classical Effort-Associated Angina)**: PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs (See Warnings)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA

WARNINGS: **Excessive Hypotension**: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated occasional patients have had excessive and poorly tolerated hypotension These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers

Severe hypotension and or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker but the possibility that it may occur with PROCARDIA alone with low doses of fentanyl, in other surgical procedures or with other narcotic analgesics cannot be ruled out In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina probably related to increased sensitivity to catecholamines Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation It is important to taper beta blockers if possible rather than stopping them abruptly before beginning PROCARDIA

Congestive Heart Failure: Rarely patients, usually receiving a beta blocker have developed heart failure after beginning PROCARDIA Patients with tight aortic stenosis may be at greater risk for such an event

PRECAUTIONS: **General**: **Hypotension**: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested Close observation is especially recommended for patients already taking medications that are known to lower blood pressure (See Warnings)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA This edema occurs primarily in the lower extremities and usually responds to diuretic therapy With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction

Drug interactions: Beta-adrenergic blocking agents (See Indications and Warnings) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina

Long-acting nitrates PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination

Digitalis Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers The average increase was 45% Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization

Carcinogenesis, mutagenesis, impairment of fertility When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose

Pregnancy Category C Please see full prescribing information with reference to teratogenicity in rats embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0 5% Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication Additionally, the following have been reported muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis pruritus, urticaria, fever, sweating, chills, and sexual difficulties Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension

In addition, more serious adverse events were observed not readily distinguishable from the natural history of the disease in these patients It remains possible, however, that some or many of these events were drug related Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2% Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0 5% of patients

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase CPK LDH, SGOT, and SGPT have been noted and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy The relationship to PROCARDIA therapy is uncertain These laboratory abnormalities have rarely been associated with clinical symptoms Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41) The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77° F (15° to 25° C) in the manufacturer's original container

More detailed professional information available on request © 1982, Pfizer Inc

Pfizer **LABORATORIES DIVISION**
PFIZER INC

"I can do things that I couldn't do for 3 yrs. including joining the human race again."

Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

© 1983, Pfizer Inc.

"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).

for the varied faces of angina

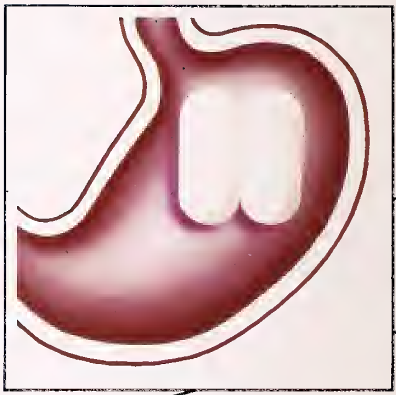
PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

*Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA *brief summary on adjoining page.*

ZORprin®
(ASPIRIN) **ZERO ORDER RELEASE**

Arthritis Therapy That Checks Out.



- ☑ Gastric distress is reduced. pH-dependent matrix virtually doesn't release in acidic stomach.
- ☑ ZORprin® (aspirin) is released in the alkaline environment of the small intestine.
- ☑ Zero-order release delivers drug at a constant rate, reducing serum peaks and valleys.

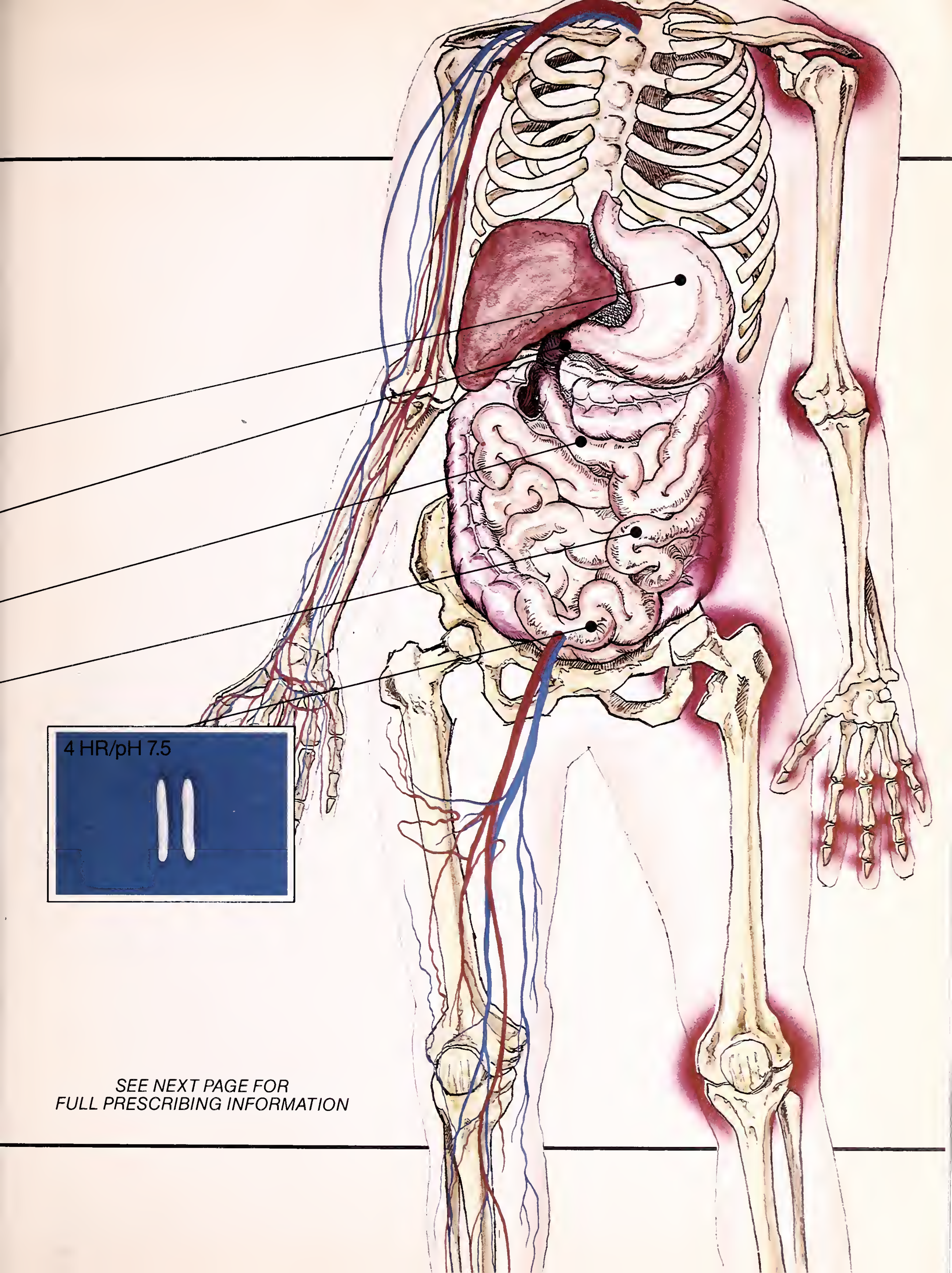
1 HR/pH 1.2
2 HR/pH 7.5
3 HR/pH 7.5

- ☑ Convenient b.i.d. dosage...enhances patient compliance.
- ☑ Economical...comparable efficacy and safety as other NSAIDs, yet costs approximately one-half as much.
- ☑ Your first step in arthritis therapy... **ZORprin®** (ASPIRIN) Zero-Order Release.

Pioneers in medicine for the family

Boots Pharmaceuticals, Inc.
6540 LINE AVENUE, P.O. BOX 6750
SHREVEPORT, LOUISIANA 71106-9989

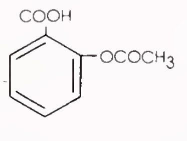
© Boots Pharmaceuticals, Inc., 1983



SEE NEXT PAGE FOR
FULL PRESCRIBING INFORMATION

ZORprin (ASPIRIN) Zero-Order Release

The structural formula of aspirin is:



DESCRIPTION: Each capsule-shaped tablet of Zorprin contains 800 mg of aspirin, formulated in a special matrix to control the release of aspirin after ingestion. The controlled availability of aspirin provided by Zorprin approximates zero-order release; the *in vitro* release of aspirin from the tablet matrix is linear and independent of the concentration of the drug. ☐ **CLINICAL PHARMACOLOGY:** Aspirin, as contained in Zorprin, is a salicylate that has demonstrated anti-inflammatory and analgesic activity. Its mode of action as an anti-inflammatory and analgesic agent may be due to the inhibition of synthesis of prostaglandins, although its exact mode of action is not known. ☐ Zorprin dissolution is pH-dependent. *In vitro* studies have shown very little aspirin to be released in acidic solutions; whereas, Zorprin releases the majority of its aspirin (90%) in a zero-order mode at a neutral to alkaline pH. It is this pH dependence of Zorprin that reduces direct contact between aspirin and the gastric mucosa, resulting in a reduction of its gastrointestinal side-effect potential. ☐ Bioavailability data for Zorprin have confirmed that plasma levels of salicylic acid and acetylsalicylic acid can be measured 24 hours after a single oral dose. This substantiates a twice daily dose regimen. Multiple dose bioavailability studies showed similar steady-state salicylate levels for Zorprin as for conventional release aspirin using the same total daily dose. Long-term monitoring of salicylate levels showed no signs of accumulation once steady-state levels were reached (4-6 days). ☐ Studies of *in vivo* prostaglandin levels (PGE2) have shown Zorprin plasma levels of salicylic acid and acetylsalicylic acid to reduce PGE2 levels 14 hours after a single oral 800 mg dose while an equivalent dose of aspirin produced a reduction of PGE2 levels only through six hours. Zorprin's effect on prostaglandins other than PGE2 has not been determined. ☐ Salicylates are excreted mainly by the kidney, and from studies in humans it appears that salicylate is excreted in the urine as free salicylic acid (10%); salicyluric acid (75%) salicylic phenolic (10%); acyl glucuronides (5%) and gentisic acid (<1%). ☐ **INDICATIONS & USAGE:** Zorprin is indicated for the treatment of rheumatoid arthritis and osteoarthritis. The safety and efficacy of Zorprin have not been established in those rheumatoid arthritic patients who are designated by the American Rheumatism Association as Functional Class IV (incapacitated, largely or wholly bedridden, or confined to wheelchair, little or no self-care). ☐ In patients treated with Zorprin for rheumatoid arthritis and osteoarthritis, the anti-inflammatory action of Zorprin has been shown by reduction in pain, morning stiffness and disease activity as assessed by both the investigators and patients. ☐ In clinical studies in patients with rheumatoid arthritis and osteoarthritis, Zorprin has been shown to be comparable to conventional release aspirin in controlling the aforementioned signs and symptoms of disease activity and to be associated with a statistically significant reduction in the milder gastrointestinal side effects (see ADVERSE REACTIONS). Zorprin may be well tolerated in some patients who have had gastrointestinal side effects with conventional release aspirin, but these patients when treated with Zorprin should be carefully followed for signs and symptoms of gastrointestinal bleeding and ulceration. ☐ Since there have been no controlled trials to demonstrate whether or not there is any beneficial effect or harmful interaction with the use of Zorprin in conjunction with other nonsteroidal anti-inflammatory agents (NSAI), the combination cannot be recommended (see **Drug Interactions**). ☐ **Because of its relatively long onset of action, Zorprin is not recommended for antipyresis or for short-term analgesia.** ☐ **CONTRAINDICATIONS:** Zorprin should not be used in patients known to be hypersensitive to salicylates or in individuals with the syndrome of nasal polyps, angioedema, bronchospastic reactivity to aspirin, renal or hepatic insufficiency, hypoprothrombinemia or other bleeding disorders. Zorprin is not recommended for children under 12 years of age; it is contraindicated in all children with fever accompanied by dehydration. ☐ **WARNINGS:** Zorprin should be used with caution when anticoagulants are prescribed concurrently, since aspirin may depress platelet aggregation and increase bleeding time. Large doses of salicylates may have hypoglycemic action and enhance the effect of the oral hypoglycemics, concomitant use therefore is not recommended. However, if such use is necessary, dosage of the hypoglycemic agent must be reduced. The hypoglycemic action of the salicylates may also necessitate adjustment of the insulin requirements of diabetics. ☐ While salicylates in large doses have a uricosuric effect, smaller amounts may reduce water excretion and increase serum uric acid. ☐ USE IN PREGNANCY: Aspirin can harm the fetus when administered to pregnant women. Aspirin interferes with maternal and infant hemostasis and may lengthen the duration of pregnancy and parturition. Aspirin has produced teratogenic effects and increases the incidence of stillbirths and neonatal deaths in animals. ☐ If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus. ☐ Aspirin should not be taken during the last 3 months of pregnancy. ☐ **PRECAUTIONS:** Appropriate precautions should be taken in prescribing Zorprin for patients who are known to be sensitive to aspirin or salicylates. Particular care should be used when prescribing this medication for patients with erosive gastritis, peptic ulcer, mild diabetes or gout. As with all salicylate drugs, caution should be exercised in prescribing Zorprin for those patients with bleeding tendencies or those on anticoagulants. ☐ In order to avoid exacerbation of disease or adrenal insufficiency, patients who have been on prolonged corticosteroid therapy should have their therapy tapered slowly rather than discontinued abruptly when Zorprin is made a part of the treatment program. ☐ Patients receiving large doses of aspirin and/or prolonged therapy may develop mild salicylate intoxication (salicylism) that may be reversed by dosage reduction. ☐ Salicylates can produce changes in thyroid function tests. ☐ Salicylates should be used with caution in patients with severe hepatic damage, preexisting hypoprothrombinemia, Vitamin K deficiency and in those undergoing surgery. ☐ Since aspirin release from Zorprin is pH dependent, it may change in those conditions where the gastric pH has been increased as a result of antacids, gastric secretion inhibitors or surgical procedures. ☐ **Drug Interactions:** (See **WARNINGS**) Aspirin may interfere with some anticoagulant and antidiabetic drugs. Drugs which lower serum uric acid by increasing uric acid excretion (uricosurics) may be antagonized by the concomitant use of aspirin, particularly in doses less than 2.0 grams/day. Nonsteroidal anti-inflammatory drugs may be competitively displaced from their albumin binding sites by aspirin. This effect may negate the clinical efficacy of both drugs. Also, the gastrointestinal inflammatory potential of nonsteroidal anti-inflammatory drugs may be potentiated by aspirin. The combination of alcohol and aspirin may increase the risk of gastrointestinal bleeding. ☐ Aspirin may enhance the activity of methotrexate and increase its toxicity. ☐ Sodium excretion produced by spironolactone may be decreased in the presence of salicylates. Concomitant administration of other anti-inflammatory drugs may increase the risk of gastrointestinal ulceration. Urinary alkalinizers decrease aspirin's effectiveness by increasing the rate of salicylate renal excretion. Phenobarbital decreases aspirin's effectiveness by enzyme induction. ☐ **Pregnancy Category D.** See **WARNINGS** Section. ☐ **Nursing Mothers:** Salicylates have been detected in the breast milk of nursing mothers. Because of the potential for serious adverse reactions from aspirin in nursing infants, a decision should be made whether to discontinue nursing or discontinue the drug, taking into account the benefit of the drug to the mother. ☐ **ADVERSE REACTIONS: Hematologic:** Aspirin interferes with hemostasis. Patients with a history of blood coagulation defects or receiving anticoagulant drugs or with severe anemia should avoid Zorprin. Aspirin used chronically may cause a persistent iron deficiency anemia. ☐ **Gastrointestial:** Aspirin may potentiate peptic ulcer, and cause stomach distress or heartburn. Aspirin can cause an increase in occult bleeding and in some patients massive gastrointestinal bleeding. However, the greatest release of active drug from Zorprin is designed to occur in the small intestine over a period of time. This has resulted in fewer symptomatic gastrointestinal side effects. ☐ **Allergic:** Allergic and anaphylactic reactions have been noted when hypersensitive individuals have taken aspirin. Fatal anaphylactic shock, while not common, has been reported. ☐ **Respiratory:** Aspirin intolerance, manifested by exacerbations of bronchospasm and rhinitis, may occur in patients with a history of nasal polyps, asthma, or rhinitis. The mechanism of this intolerance is unknown but may be the result of aspirin-induced shunting of prostaglandin synthesis to the lipoxygenase pathway and the liberation of leukotrienes, e.*g.* slow-reacting substance of anaphylaxis. ☐ **Dermatologic:** Hives, rashes, and angioedema may occur, especially in patients suffering from chronic urticaria. ☐ **Central Nervous System:** Taken in overdoses, aspirin provides stimulation which may be manifested by tinnitus. Following initial stimulation, depression of the central nervous system may be noted. ☐ **Renal:** Aspirin rarely may aggravate chronic kidney disease. ☐ **Hepatic:** High doses of aspirin have been reported to produce reversible hepatic dysfunction. ☐ **OVERDOSAGE:** Overdosage, if it occurs, would produce the usual symptoms of salicylism: tinnitus, vertigo, headache, confusion, drowsines, sweating, hyperventilation, vomiting or diarrhea. Plasma salicylate levels in adults may range from 50 to 80 mg/dl in the mildly intoxicated patient to 110 to 160* mg/dl in the severely intoxicated patient. An arterial blood pH of 7.1 may indicate serious poisoning. The clearance of salicylates in children is much slower than adults and should receive due consideration when aspirin overdosages occur in infants; salicylate half-lives of 30 hours have been reported in infants 4-8 months old. Treatment for mild intoxication should include emptying the stomach with an emitic, or gastric lavage with 5% sodium bicarbonate. Individuals suffering from severe intoxication should, in addition, have forced diuresis by intravenous infusions of sodium bicarbonate and dextrose or sodium lactate. In extreme cases, hemodialysis or peritoneal dialysis may be required. ☐ (*A plasma salicylate level of 160 mg/dl in an adult is usually considered lethal.) ☐ **DOSAGE & ADMINISTRATION:** *In order to achieve a zero-order release, the tablets of Zorprin should be swallowed intact.* ☐ *Breaking the tablets or disrupting the structure will alter the release profile of the drug.* ☐ *It is recommended that Zorprin be taken with sufficient quantities of fluids (8 oz. or more).* ☐ **Adult Dosage:** For mild to moderate pain associated with rheumatoid arthritis and osteoarthritis, the recommended initial dose of Zorprin is 1600 mg (2-800 mg tablets) twice a day. Because of Zorprin's prolonged release of aspirin into the bloodstream, Zorprin tablets may be taken as a b.i.d. dose. Further adjustment of the dosage should be determined by the physician, based upon the patient's response and needs. Since it will take 4-6 days to reach steady-state levels of salicylic acid with Zorprin, it is recommended dosages be given for at least one week before further adjustment. In general, patients with rheumatoid arthritis seem to require higher doses of Zorprin than do patients with osteoarthritis. ☐ **Zorprin is not recommended for children below the age of 12.** ☐ **HOW SUPPLIED: Zorprin Tablets 800 mg;** plain, white capsule-shaped tablets. ☐ Bottles of 100 Tablets — NDC 0524-0057-01. ☐ **Caution:** Federal law prohibits dispensing without prescription. ☐ U.S. Patent No. 4,308,251 ☐ **Manufactured and Distributed by: BOOTS PHARMACEUTICALS, INC., Shreveport, Louisiana 71106 U.S.A.**

12/8/83 0057-04

Pioneers in medicine for the family

Boots Pharmaceuticals, Inc.
6540 LINE AVENUE, P.O. BOX 6750
SHREVEPORT, LOUISIANA 71106-9989

December 8 was **Merle E. Wehner, MD,** Day in Manistique and Schoolcraft County. Doctor Wehner was honored for 37 years of dedicated medical practice at a community dinner... Reelected to three year terms on the W.K. Kellogg Foundation Board of Trustees were **Russell G. Mawby, MD,** and **Robert D. Sparks, MD,** both of Battle Creek. ... **Bertram Pitt, MD,** Ann Arbor is a member of the Young Investigator Awards Committee of the American College of Cardiology. Doctor Pitt will be involved in judging presentations of five student finalists during the College's 33rd Annual Scientific Session in Dallas in March. ... **Angelos A. Kambouris, MD,** Henry Ford Hospital, is new president-elect of the Midwest Surgical Association. He is currently president of the Detroit Academy of Surgery. ... **Margaret Douglass, MD,** Detroit, is new president-elect of the Michigan Dermatological Society. ... The American Lung Association of Michigan inaugurated a volunteer's column in its newsletter by spotlighting **Clyde R. Flory, Jr., MD,** Lansing, as a dedicated volunteer with that group. ... **John R. Rodger, MD,** Kalamazoo, delivered the invocation at the 50th reunion of the U-M Medical School Class of 1933. ... **Ezra V. Bridge, MD,** Port Huron, was honored at a luncheon for 25 years of service to the St. Clair County Health Department's tuberculosis control and treatment program. ... New Medical Director of the Harper-Grace Physical Medicine and Rehabilitation Center is **Mark F. Rottenberg, MD,** Southfield. He continues to serve as chief of the Musculoskeletal Unit at the Institute. ... **Gerald F. Conway, MD,** Birmingham, was recently installed as president of the Oakland County Medical Society. **Frederick V. Minkow, MD,** Bloomfield Hills, was chosen president elect. ... New president of the Eye Bank Association of America is **Busharat Ahmad, MD,** Marquette. He has been medical director of the Upper Peninsula Lions Eye Bank since its organization in 1971. ... **Bruce Lemon, MD,** Birmingham, has been named chairperson of the Providence Hospital Foundation. ... **Robert Segula, MD,** top medical executive at Pontiac General Hospital has retired from the position of vice president for medical services. ... Addison physician **Amos P. Rawson, MD,** was honored with a retirement banquet given by the board, medical staff and administration of Addison Hospital. For 25 years Doctor Rawson and his wife were missionaries in Africa before returning to the US in 1972. ... **George D. Zuidema, MD,** a leading medical scholar and administrator at Johns Hopkins University, was appointed to the new position of vice provost for medical affairs at the University of Michi-

Continued on next page

MEDICAL PRACTICE IN THE COMPUTER AGE

WEDNESDAY & THURSDAY
MARCH 7 & 8, 1984

Hyatt Regency Dearborn
Dearborn, Michigan

ABOUT THE PROGRAM

The OHEP Medical Education Committee is pleased to present this two day conference on medical computing. It is designed for the physician seeking a basic understanding of computers and the physician with experience who is looking for new information on computer applications.

Purchasing a personal computer? Considering a system for your practice? Looking for the latest developments in hardware and software? Trying to get more out of your present computer? This program is designed for you.

PROGRAM HIGHLIGHTS

- How to get the most out of your computer
- How to decide if you need a computer and how to choose one for your practice
- How the information revolution will affect your practice
- Computerized DRGs Assessment
- How future computer technology will affect your practice
- Group demos of medical practice systems
- Informal information exchange
- Demonstrations of medical computer applications
- More than twenty computer exhibits

CONTINUING EDUCATION CREDIT

Seven hours on the first day and eight hours on the second of Category I Continuing Medical Education is offered by St. Joseph Mercy Hospital, Pontiac.

REGISTRATION

You may register for either or both days of the program. Registration fees include conference luncheons. Deadline for receipt of registrations is March 2, 1984.

Physicians $ 65.00 each day
$110.00 both days

Physicians-in-training and Others
$ 45.00 each day
$ 75.00 both days

For registration information call: 313·377·4360

OAKLAND HEALTH
EDUCATION PROGRAM
VARNER HOUSE
ADAMS AT BUTLER
ROCHESTER, MICHIGAN 48063

gan. Doctor Zuidema is a Michigan native and former faculty member at the U-M Medical School. ... **Edwin H. Gullekson, MD,** Flint, is new president of the Genesee County Medical Society. **George H. Greidinger, MD,** Flint, is new president-elect. ... **Krishnasswami Rajan, MD,** Lapeer, is new president of the Lapeer County Medical Society. **Isak Berker, MD,** Lapeer, is new president-elect. ... In recognition of its more than 30 years of service and leadership in the treatment of alcoholism, Brighton Hospital was presented with a Special Tribute from the State of Michigan recently. The award was presented by State Representative Fred Dillingham (R-Fowlerville) during Alcohol Awareness Week. ... **Robert J. Rathburn, MD,** Flint, was honored for seven years of service as medical coordinator with the Flint Fire Department paramedics. Doctor Rathburn was presented a Citizen's Award by Flint's mayor. ... Two physicians from the Ann Arbor VA Medical Center recently took top honors in the state for papers presented at the annual meeting of the Michigan Chapter of the American College of Physicians and the Michigan Society of Internal Medicine. They are **Douglas Schwartz, MD,** and **William O'Neill, MD.** ... New president of the Kalamazoo Academy of Medicine is **James Dolan, MD. Jeffrey Block, MD,** was named president-elect. ... Three physicians at Harper Hospital recently received a grant from the Michigan Heart Association for their research on heart disease: **Theodore Wizenberg, MD,** Farmington Hills; **Jarslaw Muz, MD,** Grosse Pointe; and **Richard Pollard, MD,** Grosse Pointe Woods. ... **Douglass A. Haddock, MD,** Kalamazoo, has been elected vice president of the Interstate Post Graduate Medical Association of North America. ... **R. Donald Eward, MD,** and **Brian L. Hotchkiss, MD,** were two of 64 "Hometown Heroes" honored by The Greater Grand Rapids Convention Bureau as being instrumental in bringing convention business to the Grand Rapids area. ... New president of the American Society of Cytology is **Bernard Naylor, MD,** Ann Arbor. ... The Keweenaw Bay Indian Community health clinic recently honored **Bhupendra H. Nanavati, MD,** Hancock, for 10 years of service to the tribe. He has been with the clinic since it opened. ... **St. Clair County Medical Society** recently received the first annual Community Service award for its program which provides free medical care to the poor. More than 50 area MDs from various specialties agreed to give free care to those without health insurance. ... Officers of the Region V Emergency Medical Service Council elected **Bernard Berman, MD,** Flint, chairman.

LABORATORY OF CLINICAL MEDICINE

MID-MICHIGAN REFERENCE LABORATORY, II, Inc.
(517) 372-8180

1322 E. Michigan Ave.
Suite 102
Lansing, Michigan 48912

930 E. Mt. Hope Ave.
Lansing, Michigan 48910

2909 E. Grand River Ave.
Suite 104
Lansing, Michigan 48912

W. E. Maldonado, M.D.
Director

Robert B. Foy, Ph.D.
Chief Executive Officer

Ann E. Chernys, M.D.
John W. Dyke, Ph.D.
Dennis E. Freer, Ph.D.
John J. Gillespie, M.D.
Ronald N. Horowitz, M.D.
John R. Kateley, Ph.D.
John J. Lyday, M.D.

Joseph R. Melvin, Ph.D.
Sandra K. Shirley, M.D.
Laurence R. Simson, Jr., M.D.
Susan M. Strate, M.D.
Carolyn M. Texera, M.D.
Irene K. Trombley, M.D.
Susan C. Weisz, Ph.D.

REFERENCE LABORATORY FOR SPECIALIZED PROCEDURES
Specimen Pickup and Delivery of Test Results Daily
Assignment is accepted from Medicare, Medicaid, Blue Shield and all other insurance carriers.

"A New Dimension in the Treatment of Alcoholism and Drug Dependency"

NAPLES RESEARCH
& COUNSELING CENTER

Offering Multi-Program Approaches for Individuals and Families Suffering from

- Alcoholism
- Drug Dependencies
- Life Adjustment
- Food Addiction

Our professionally staffed JCAH approved chemical dependency program is covered by CHAMPUS and most other group health care plans.

CALL US TODAY for a Confidential Evaluation or Intervention Assistance
(813) 775-4500

9001 Tamiami Trail East, Naples, Florida 33962
An Affiliate of The Palm Beach Institute Family of Programs, Incorporated
]

By Lonnie R. Bristow, MD

How the AMA views government's health care proposals

Pressure on physicians toward becoming "participating" physicians comes from Blue Cross Blue Shield and commercial companies who use misleading and inflammatory language in "explanation of benefits" letters to subscribers. These are letters which imply that *any* physician's charge which is more than their benefit payment is, per se, unreasonable — or which offer to defend beneficiaries in any collection efforts brought by physicians.

Such pressure derives also from increased national consideration of mandating assignment under Medicare. The past few years have seen increasing discussion in government sectors of the potential viability of legislation to mandate assignment as a condition of payment under Medicare. Those efforts will continue and further intensify as the present administration seeks ways of paring a federal deficit now projected to reach $267 billion in 1988.

Medicine captive?

If these trends and forces I've just identified continue to operate into the future, the AMA Council on Medical Service can foresee only one logical outcome.

Here's the scenario:

1. If the acceleration in spending for health care continues to be fueled by the insulation of both the individual physician and patient from cost concerns . . .

2. If unions, consumer groups and the public continue to press for comprehensive coverage of physicians' services . . .

3. If payors continue to react by marketing more UCR-based policies requiring physicians' "participation" as a condition of payment — and consumers continue to purchase such coverage with both groups believing this is the way to control costs . . .

4. If federal antitrust agencies continue to put the kibosh on any attempts by the profession to deal with these problems through discussions and negotiations with payors . . .

5. And if such mandated "participation" also becomes a part of the Medicare law . . .

Then medicine in effect can and will become the captive of government and third party payors as it already has in a number of other countries. The level of payment will be determined solely by those payors for the vast majority (if not all) of the professional services they render.

The AMA Council on Medical Service believes there will be a resulting inevitable mediocrity in the quality of medical care. Control of payment gives control of the service and, to a considerable degree, the quality of that service.

Let me now define what I mean by "quality of care." I hope you'll remember it when I refer to this definition again in a few minutes. I don't mean frills and luxuries — but those decisions impacting morbidity, length of disability or family life dislocation.

There are honest skeptics who say, "Let's not panic, UCR-based payment and full-service programs which prohibit balance-billing have been financially good to the profession and have assured access for the public. Maybe the Council on Medical Service is over-reacting and is frightened of shadows and ghosts." How valid is that question?

We have set five prerequisites for the profession to become a captive of government and third party payors. Four already are in place and the fifth is: If mandated participation becomes a part of the Medicare law.

Criminal penalties

Let me update you on recent events. On October 19 the U.S. House Ways and Means Committee marked up its Reconciliation Bill for the Medicare program. They debated a recommended proposal for a *major* change in public policy which came from their Subcommittee on Health. That proposal was put together without obtaining or permitting any prior testimony from the parties *most* affected by this change.

The change would have temporarily converted the Medicare program (which has always been primarily based on achieving a particular age), overnight, into a Medicaid or welfare program (which has always been based on level of income). It was a two-part proposal and the most controversial part would not have saved the federal budget *any* money!

The AMA's view of crucial federal politics affecting medicine is provided in the following article. The article is taken from the speech delivered by Lonnie R. Bristow, MD, San Pablo, CA, Chairman of the AMA Council on Medical Service at the 1983 MSMS Public Affairs/Leadership Conference. Copies of his full speech are available by contacting MSMS headquarters.

Doctor Bristow at MSMS Public Affairs/Leadership Conference in Lansing.

How was this to be done? They proposed coupling together a freeze on any increase in the economic index with a mandate that any physician treating a Medicare patient as a hospital inpatient *must* accept the government's determination of payment as payment in full, regardless of whether the patient is fully capable and possibly willing to pay a more realistic fee.

In other words, the government would decide what the fee should be for a Medicare patient, not simply what he or she was willing to pay for the service, and would prohibit any other voluntary arrangement. That is how the Medicaid program has functioned for almost two decades.

The proposal further specified that physicians who did not go along and who worked out a mutually agreeable arrangement with any patient for balance billing could be punished by being thrown off the hospital staff or having the hospital thrown out of the Medicare system. And the physician could also be jailed as a criminal!

On October 19 the full House Ways and Means Committee voted this proposal down 18 to 15. But the chairman made a highly unusual arrangement to have these irrevocably joined concepts reconsidered when the reconciliation package reached the floor of the House — still without testimony from the parties most directly concerned: The physicians of this country and their elderly patients!

Joining the mandatory assignment matter onto the freeze proposal would not save the federal budget one additional dollar. But whether one agreed with the philosophic wedge that was being driven or not, it is simply not the American way to make important decisions, affecting a defined constituency, without permitting opportunity for testimony in open hearing by those constituents.

There is no national emergency that could justify this patently unfair tactic by the chairman of the House Ways and Means Committee, the Honorable Daniel Rostenkowski, easily one of America's five or six most powerful politicians. At this moment, many components of organized medicine are making a maximum effort to neutralize this effort.

NHI in two years?

On Friday, October 21, I was on a seminar panel with Mr.

Continued on next page

Rostenkowski in his home city of Chicago before an audience of approximately 1,400 representatives of business, labor and the insurance industry. After Mr. Rostenkowski spoke, he received this question from someone in the audience: "Will we have nationalized health insurance soon?" He said, "Not this year, and probably not in the next year or two."

It is for those reasons that the AMA Council on Medical Service believes it is time to re-evaluate the association's policy that UCR be the preferred basis for all third-party payments to physicians, and to consider recommending a change to an indemnity system of payment for the majority of services provided by physicians. By "majority of services" we mean basic coverage; but we exclude catastrophic or umbrella coverage which we feel should continue on a UCR basis. The set indemnity amount would be determined by the payor itself on the basis of claims experience, public demand, negotiation with insureds, and other relevant factors.

Such a change would seem to offer a number of advantages to patients, physicians and third parties as well, particularly over the long term.

For patients, it would assure their continued access to care commensurate with their needs and priorities, *NOT* through external regulation of fees, but through the more effective mechanism of the marketplace, by increasing both physicians' and patients' cost-awareness. The fee would again become the business of the physician and patient, with increased sensitivity in each to the quality and costs of care provided.

The patient would have a more substantial incentive to seek a physician whose fees are reasonanbly related both to the patient's satisfaction with care and to the amount his or her insurance program pays, and to explore the reasons for differences in physicians' charges. It would allow patients continued freedom to seek the best in medical care, rather than being increasingly restricted to "participating" providers as a condition for insurance coverage.

For third parties, rate determination should be simpler under an indemnity approach; payors can establish premiums on the basis of prospective analysis of what the plan pays rather than on a statistical array of physician charges; administrative costs should be significantly less. For government programs especially, it provides an alternative which permits more precise budgetary forecasting without further restructions on type or duration of services covered or massive increases in enrollee co-payments. For nation-wide programs the indemnity amounts could vary from one region to another based on cost-of-living differences. **Market forces** would act to insure that the indemnity amounts under **private plans** would be set at a reasonable and competitive level, and increased as economic conditions dictated. With the Medicare program, consumer and professional groups alike could continue their advocacy for reasonable and economy-indexed increases in indemnity payment levels, just as they do now under the present reimbursement approach.

Partners for quality

Finally, **for the profession,** the Council believes that this approach can bring improved patient-physician interaction, since neither physician nor patient will have false expectations of the amount of third party payment. In addition, **uncoupling third party payment from physicians' charges will reduce legislative and political pressure for mandating physician "participation" as a condition of insurance payment — which in effect would clearly create a maximum fee schedule — uncoupling would help preserve for the profession the continued freedom to charge what it believes to be a fair and equitable fee, subject to the normal and effective constraints of the health care market.**

That specific ability and the unique relationship thus established with the individual patient will keep decision-making about the quality of care as a partnership judgment of the individual patient with his or her physician. Without that reinforced relationship, the AMA Council believes it is inevitable the control of quality of care decisions will default into the hands of the third party payors.

The Council recognizes that the majority of physicians may in fact prefer to accept a lessor, but guaranteed payment from the third party rather than trying to collect all or even part of their fee from the patient. But even if this is so, **we believe it is essential that physicians clearly understand what the Council perceives to be the inevitable consequences of that preference,** so that they can make a deliberate and informed choice.

You've heard about Mr. Rostenkowski's timetable; act accordingly.

Competence counts

Hurley Medical Center photo

In selecting a doctor, 74 percent of Americans consider competence, not cost.

Competent doctors remain the key to health. But competence isn't immunity to litigation.

Consider our competence – and our professional liability protection and strong-defense philosophy.

We defend you against non-meritorious claims. We won't settle a claim without your approval or merely to cut our defense cost.

PICOM
Physicians Insurance Company Of Michigan
4277 Okemos Rd., Box 1000
Okemos, Michigan 48864
(517) 349-6500
(313) 557-4845
1-800-292-1036

Do you know

a physician
with problems
of alcoholism,
drug abuse,
emotional illness
or other
difficulties
which interfere with
his or her ability
to practice medicine?

If so, please contact your MSMS Program to Assist Impaired Physicians through Katie Brewbaker at MSMS headquarters, (517) 337-1351.

AAMA seeks certification of all medical assistants

The American Association of Medical Assistants (AAMA) has announced its support for credentialing or certification of all medical assistants.

The AAMA further is recommending that those who already have credentials complete the revalidation requirements by 1993 or lose their CMA (certified medical assistant) credential.

The recommendations by the 27-year old association, which is the oldest and largest medical assisting group in the US, were included in a five-year plan which was unveiled to nearly 1,000 members attending the group's national convention in New York City in October.

In development for nearly two years, the plan was created by a team of nine medical assistants who were appointed to the Long Range Planning committee in 1981. The team included Shirley Licking, CMAA, Jackson.

The first time in the organization's history that a strategic plan has been written, the objective was "to take the necessary steps to move the profession forward," according to Ms. Sellars.

Goals for the current five-year plan include the following:

- Positive public awareness of medical assisting as a profession and the AAMA as its representative;
- Well-informed, enthusiastic members who are committed to professionalism and the Association;
- Protection of the medical assistant's right to practice through legislation and credentialing;
- Certification that is recognized as evidence of entry-level competency at current standards of practice;
- Education that prepares the medical assistant to provide competent service to employers and patients;
- Qualified, competent, committed volunteer leaders.

"Unfortunately, there still are far too many publics who do not know what a medical assistant is," stated Ms. Sellars. "Therefore, the AAMA must promote the identity of the occupation, and further, the stature of its members, through education and credentialiing."

To support the credentialing effort, the AAMA will publish a number of materials that promote the certification program, including a promotional brochure, a candidate's packet with information to help medical assistants prepare for the test, and a publication to help AAMA chapters conduct a certification review course.

In addition, the plan calls for the establishment of a registry of Certified Medical Assistants, with participation in the registry one of the requirements for maintaining certified status. Target date for the registry to be in operation is 1988.

Predicting that state legislatures will address the issue of credentialing medical assistants in the years ahead, the plan addresses this area by calling for a regular analysis of the occupation using the DACUM method to analyze the functions performed by the medical assistant. The function of the current AAMA Legislation Committee will be revised to include the study of issues related to the practice of medical assisting and the drafting of policy statements.

"Our ultimate goal is that we want state legislatures to recognize our certification rather than state licensure as a requisite to practice," says Sellars.

ADVANCEMENTS IN CARDIAC THERAPY
. . . Applications for Today into Tomorrow

A program of the Detroit-Macomb Hospital Corporation
For cardiologists, cardiovascular surgeons, internists and other interested physicians

Saturday April 14, 1984 — South Macomb Hospital, Warren

- Intracoronary Thrombolysis, Intravenous Thrombolysis, Intravenous Nitroglycerin for Acute Myocardial Infarction, Laser Vaporization of Coronary Thrombosis and Atherosclerosis, Balloon Angioplasty, Therapeutics in Special Situations
  C. Richard Conti, MD, professor of medicine; chief, Division of Cardiology, University of Florida, Department of Medicine, Gainesville, Fla.
- Heart and Heart-Lung Transplantation
  John C. Baldwin, MD, assistant professor of cardiovascular surgery, Stanford University School of Medicine, Stanford, Calif.
- Treatment of Congestive Heart Failure Based on the Assessment of Cardiac Performance
  Joshua Wynne, MD, assistant professor of medicine, Harvard Medical School, Boston, Mass.; director, Noninvasive Cardiac Laboratory, Brigham and Women's Hospital, Boston, Mass.
- Aggressive Management of Coronary Artery Disease Risk Factors: Is It Worth the Trouble?
  William P. Castelli, MD, medical director, Framingham Heart Study, Framingham, Mass.; lecturer of preventive medicine, Harvard Medical School, Boston, Mass.
- Indications for Pacemaker Therapy, Selection of Optimal Pacer Mode
  Robert G. Hauser, MD, associate professor of medicine, Rush Medical College; Chicago, Ill.; director, Pacemaker Surveillance Program, Rush-Presbyterian-St. Luke's Medical Center, Chicago, Ill.

Seven Hours Category I Credit

Registration fees, including lunch: $90 for physicians, $25 for physicians in training and allied health personnel
To ensure seating, registration is encouraged by April 2.

To register: Send check payable to DMHC Annual Seminar Fund to Detroit-Macomb Hospital Corporation, Department of Medical Affairs, 7815 East Jefferson, Detroit, Mich. 48214; 313-821-6000, ext. 270

AMA reports available at MSMS office

MSMS has copies of the following general-interest reports adopted by the 1983 AMA Interim House of Delegates in their Dec. 4-7 meeting in Los Angeles. The reports listed here are available by contacting Mert Scholten at MSMS headquarters, 120 W. Saginaw St., East Lansing, 48823.

Report on Surrogate Mothers from the Judicial Council

Preferred Provider Organizations from Council on Medical Service

CDC Funding from the Board of Trustees

Asbestos-Related Illness from the Board of Trustees

Tax status of Medicare Expenditures from the Board of Trustees

Cost and Financing Medical Education from the Council on Medical Education

JCAH Manual Review from the Board of Trustees

Early Detection of Breast Cancer from the Council on Scientific Affairs

Nonsmoking in Hospitals from the Council on Scientific Affairs

Physicians Guide to Asbestos-Related Diseases from the Council on Scientific Affairs

Drug Substitution — Definition of Terms from the Council on Scientific Affairs

Acquired Immune Deficiency Syndrome (AIDS) from the Board of Trustees

Pharmaceutical Marketing from the Council on Scientific Affairs

Exercise Programs for the Elderly from the Council on Scientific Affairs

Caffeine Labeling from the Council on Scientific Affairs

AMA's Role in Technology Assessment from the Council on Scientific Affairs

A Guide to the Hospital Management of Injuries Arising from Exposure to or Involving Ionizing Radiation from the Council on Scientific Affairs

Health Care for an Aged Population from the Board of Trustees

The Insanity Defense in Criminal Trials from the Board of Trustees

Voluntary Health Planning from the Council on Medical Service

Study of Professional Liability Costs from the Board of Trustees

ARIZONA MEDICAL CAREERS
Health Care Industry . . . Sun Valley Country

Our client, a growth oriented, integrated health care organization, with hospitals and clinics in the Southwest, requires Board eligible or certified general practitioners and medical/surgical specialists for new and established practices.

We are particularly interested in physicians for internal medicine, family practice, pediatrics, obstetrics, gynecology, oncology, orthopedics, otolaryngology, general surgery and anesthesiology.

Here is an opportunity to work either in a sophisticated, metropolitan medical environment providing educational and teaching opportunities, or a rural setting offering a substantial practice with outdoor recreational potential second to none.

Sound interesting? Based on your financial needs, our client will offer appropriate income guarantees, incentives, relocation expenses and total malpractice insurance.

Please send your curriculum vitae and professional references.

Suite 311-D
3020 E. Camelback Rd.
Phoenix, AZ 85016

an equal opportunity employer m/f/h

YOUR INCOME
Employees' Salaries
OFFICE RENT
Utilities

COULD YOU MAINTAIN YOUR OFFICE EXPENSES DURING A PERIOD OF DISABILITY?

At age 40, your chances of becoming disabled for up to 6 months are 1 out of 3...1 out of 5 could be disabled up to 2 years...1 out of 7 could be disabled up to 5 years.*

You've probably insured your own income, but what about your employees' salaries, your office rent, your professional liability premiums, etc. etc. Check these features of the Professional Overhead Expense plan sponsored by the MSMS.

- ☑ Up to $3,000 monthly benefit
- ☑ Waiver of Premium
- ☑ Survivors' Benefits
- ☑ Professional liability premiums are a covered expense
- ☑ Expenses covered include rent, utilities, employees' salaries, accountant services, plus many more

"we're here to help"

Stratton–Cheeseman & Associates, Inc.
1305 Abbott Road • P.O. Box 1563 • East Lansing, Michigan 48823
Call Toll Free: **800-292-1966**

*1979. The National Underwriter Company

By Martha Climo

Doctor Powsner — dynamic role model

Rhoda Powsner is a cardiologist and a lawyer.

She is an MSMS delegate, an alternate delegate to the AMA, and editor of the Washtenaw County Medical Society bulletin.

She is a clinical instructor in internal medicine at the University of Michigan. She is a member of many specialty societies, has been listed in *Who's Who in American Women* since 1973 and has presented and published numerous papers.

She is a member of the Arbitration Advisory Committee to the Michigan Insurance Commission.

She is the wife of pathologist Edward Powsner, MD, and they are the parents of four children: Seth, 30, a psychiatrist in private practice in Chicago; Rachel, 28, a fellow in nuclear medicine at Peter Bent Brigham Hospital in Boston; Ethan, 24, a judicial clerk for the 20th Circuit Court in Michigan, and David, 23, a senior in law school at Case Western Reserve University in Cleveland.

Busier

She has accomplished all this through hard work and love of it. Today, as a vibrant, dynamic 53-year-old, she finds herself busier than ever.

Doctor Powsner, who lives in Ann Arbor, is a solid role model for young women entering the medical field, and provides insights based on personal experience which are worthwhile for all physicians.

She is particularly concerned with the relationship between medicine and society and wants to preserve the health care system so that it delivers good care.

"We must pay attention to the personal and social needs as well as the ethical issues of the people, so we are appropriately responsive to the times," she says.

She participated in the implementation of the Michigan Malpractice Arbitration Program, as the MSMS representative on the Arbitration Advisory Committee to the Insurance Commission. She served as co-chairperson of the Washtenaw County Medical Society-Washtenaw Bar Association Commission which was responsible for beginning a

---

Ms. Climo is a Lansing-area freelance writer.

dialogue between the legal and medical communities before the malpractice crisis of 1975.

Regarding malpractice issues, Doctor Powsner observes, "Premiums are going up because of the number of cases filed and larger awards. The trend cannot continue.

"Doctors are scared. There's so much pressure, something has to give," she says.

One alternative to the court system is arbitration, which has been shown to be less costly and less time-consuming and more consistent in its awards.

"But arbitration is merely an alternative," she says. "Other facets of the malpractice situation need careful study, including patients' and lawyers' expectations. The medical malpractice problem is merely one part of the entire professional liability issue which confronts our society."

Her views are reflected in the recent decision of MSMS and the State Bar to take the medical malpractice situation to the people for answers to problems which are society-wide.

Coup

Doctor Powsner only recently fulfilled her dream to get a law degree. It's not surprising that this was on her agenda of challenges, as both her parents were lawyers.

"My mother and my aunt had law degrees, but never practiced. I wasn't just going to be educated. I was going to use my training," she says.

After Doctor Powsner's fourth child went to college in 1977, she began law school at the University of Michigan. With a little shuffling of her schedule and another physician covering while she went to class, she completed her studies.

She talks about law school with a twinkle in her eye, obviously feeling very satisfied with herself. It's as if she pulled off one more coup successfully and she derives a great deal of pleasure from that knowledge.

"It was fun. It was great," she says. "I had a chance to put together things I had always wondered about."

And as a result of her new degree she has been able to merge her interests in law and medicine and make a contribution in this area.

"I just try to do what is right and fair," she says. "And I can now deal with medical/legal issues more knowledgably."

Control

She has much to say on many subjects. She believes that everyone should take control of their lives; she knows what she wants and goes after it.

She dreamed of becoming a physician at the age of 13, and decided on cardiology when a close cousin had rheumatic fever.

She graduated from high school at the age of 15. Then it was on to Adelphi College and then to Yale Medical School where she met her husband. He is now head of the section of nuclear medicine at St. John Hospital, Detroit.

"There was never any question in my mind that I was going to have a career and a family. I've just had to make many adjustments, adaptations and compromises," she says. "Mostly, I've had to juggle schedules.

"I have a strong sense of family which dictated much of what I did over the years," Doctor Powsner says. "When I had a more compelling problem at home or at work I attended to it."

"We wouldn't be as mature ourselves without having kids," she says. She had help in combining her marriage and career, she adds. Husband Edward has been extremely supportive through the years, and often took care of the babies at night while she took calls. "Friends and family all have helped. I was fortunate occasionally to get assistance from the men in charge. It's hard to develop a network, but it does get easier with time."

Anomaly

On the changing medical world:

"Women in medicine no longer are an anomaly. One-third to one-half of the medical students are female. If this trend continues, if women finish their training, continue to work, enter institutions and participate, then they will have a voice and will shape policy," Doctor Powsner says.

"But it's not going to just happen. Women will have to participate actively. They will have to overcome stereotypes.

"When women want to succeed, they do a lot and they do very well," she says.

"But to succeed, women can't have any questions about whether or not they want to accomplish the goal. They can't be burdened with too many 'but ifs,'" Doctor Powsner says.

"Furthermore, women must learn to delegate responsibility. They won't do it well, unless they really want to. They can't be ambivalent. They have to make up their minds what their goals are and follow through in the short and the long run," she explains.

"The vast majority of women's problems are not related to what they actually do, but what they perceive they do. Women have to recognize realistically that they're doing a responsible job. It is only then that they can cope with their concerns when problems arise.

"And they have to keep evaluating what they're doing, the benefits and costs, then modify their behavior. That's part of growing up. Then they can have their careers and their families," she says.

"Often women worry too much. They can't take control. They become uneasy and depressed. And unfortunately no one is there to help them. What women need are positive role models and networks, which can replace the traditional extended families."

And if it's a positive role model Michigan women are seeking, they certainly need look no further about them than to Ann Arbor's Rhoda Powsner — physician, lawyer, professional leader, wife, mother . . .

Summary of proceedings, Michigan Board of Medicine

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are summarized below by MSMS legal counsel from official memoranda to MSMS. Any subsequent actions of the board will be printed in future issues.

Doctor Involved: William H. Carranza, M.D.
Complaint: (as amended) That the physician had pled guilty to unlawful possession of cocaine, Oakland County Circuit Court. By Court Order the physician attended two programs for rehabilitation for alcohol and substance abuse.
Decision: License suspended two years, commencing September 10, 1983.
Comments: Attorney General's Opinion indicates that although the physician was convicted of a felony, some of the evidence actually before the Board was sketchy, resulting in a two-year license suspension.
Dated: December 7, 1983

Doctor Involved: Bernard Levine, M.D.
Complaint: Surgery misadventure
Facts: Tubal ligation allegedly improperly performed, both left and right fallopian tubes. Also, allegedly failed fully to advise patient of surgery results and pathology report.
Decision: Consent Order, reprimand. August 8, 1983.
Status: Final
Dated: December 7, 1983

What you don't know about Accounting can hurt you.

Read: What Every Doctor Should Know About Modern Accounting.

Written by a practicing C.P.A., this book gives guidance in five important areas:
- How do you know if you *need* a C.P.A.?
- What to look for when choosing a C.P.A. firm.
- "Big" vs. "Small" C.P.A. firms: an evaluation of both.
- Computerization: how does it help?
- How to interview to find the "right" firm.

WRITE OR CALL FOR THIS *FREE* BOOK, NOW.

Sanford Mandell, C.P.A. P.C.
31275 Northwestern Highway
Woodcreek Officenter
Farmington Hills, MI 48018
(313) 855-3535

Transportation:
Delivery of patient specimens is the first step in providing laboratory testing services. The Advance Medical & Research Center, Inc. transportation department provides specimen pick-up and twenty-four-hour turnaround time of test results by employing more than 60 couriers, daily air flights and report transmission by high-speed teleprinters.

ADVANCE MEDICAL & RESEARCH CENTER, INC.

1270 Doris Rd. • Pontiac, Michigan 48057 • (313) 373-9120

Branches: Allen Park, Alpena, East Jordan, Flint,
Grand Rapids, Kalamazoo, Lansing, Monroe, Traverse City

Serving the medical profession since 1963

Damaged placentas

Major developmental defects, including cerebral palsy, vision disorders and problems in perceptual skills, have been linked to a specific lesion in the placenta, reports a pathologist at Michigan State University. The placenta is a fetal organ which nourishes and protects the unborn child.

Evidence implicating a condition termed "Hemorrhagic Endovasculitis (HEV)" with the developmental defects have been uncovered by Charles H. Sander, MD, MSU professor of pathology and director of the Michigan Placental Tissue Registry.

The new research, a clinical and epidemiologic followup still in pilot stages, arose from Dr. Sander's examination of nearly 6,000 problem placentas which revealed HEV in one of 10 cases.

First described by Sander in 1980, HEV involves destruction of placental blood vessels and fetal red blood cells with hemorrhage (fetal blood loss) into the placenta. A significant association between this lesion and stillborn or growth retarded infants has previously been established. A number of mothers have had HEV-affected placentas complicating several or successive pregnancies.

Stress and hearts

Interpersonal stress affects the hearts of Type A people with greater intensity than it afflicts hearts of more relaxed Type Bs, according to research by behavioral scientists at Michigan State University.

Computer analysis of electrocardiograms taken of MSU students while they played stress-laden computer games showed changes suggesting that there may be more vigorous stimulation by sympathetic nerves of left ventricles in hearts of Type As than in Type Bs.

Research on cardiovascular effects of social competition and information processing has been carried out in a computer-controlled environment over the past five years by the MSU Department of Psychiatry. The department is a unit of MSU's College of Human Medicine and College of Osteopathic Medicine. The work has been funded by the National Heart, Lung and Blood Institute.

CATs' eyes

A University of Michigan researcher has found that advanced computer imaging techniques can help eye doctors make diagnoses that previously required potentially painful exploratory surgery.

Stephen S. Gebarski, MD, assistant professor of radiology in the division of neuroradiology at the U-M Medical School, said that high-resolution, computer assisted tomography (CAT) scans "enable physicians to compile a series of the fine-detail, reconstructed, enhanced X-ray views of the orbit and the globe not otherwise visible."

"The ophthalmoscope," Dr. Gebarski explained, "uses visible light to aid the physician in viewing the eye's inner lining or retina. It doesn't, however, afford a deep view, which meant that patients many times had to undergo the discomfort and anxiety of exploratory surgery before a more definitive diagnosis could be made regarding abnormalities of the deep eye or orbit. Ultrasound, while useful, cannot provide fine resolution of small abnormalities."

Dr. Gebarski, whose research paper is based on 275 case studies, said the CAT scan "allows definitive diagnosis and therapy of many previously puzzling eye diseases."

Among these diseases, he noted, are such tumors as ocular melanoma and retinoblastoma. Other diseases such as inflammatory posterior scleritis, often found in patients with rheumatoid arthritis, can also be more accurately diagnosed and treated with the aid of a high-resolution CAT, Dr. Gebarski reported.

Pill schill

Social pressure to be thin drives nearly one of every three young women to use diet pills, even though most don't believe that the pills help them lose weight, according to a Michigan State University study.

In a survey of 944 MSU undergraduates (most between 18 to 21 years old), researchers Lawrence Krupka and Arthur Vener found that 30.1 percent of the women surveyed had used diet pills in the previous year, compared to just 3.7 percent of the men questioned.

The study also showed that the majority of these women (86 percent) believed that diet pills were useful only on a short-term basis, or that they had limited or no appetite-suppressant effect, or were completely ineffective.

"The drive to be lean is very powerful in Western culture," explains Vener, a professor of social science. "Women are constantly directed to be thin and therefore acceptable to others, especially to men, and this urges them to do whatever's necessary to try to lose weight.

"What we're seeing in this study," he adds, "is a pervasive desperateness among young women to obtain and maintain a lean silhouette."

Krupka, a natural science professor, and Vener, conducted the study because of their growing concern about the health effects of over-the-counter diet pills containing the drug phenylpropanolamine hydrochloride (PPA). Used widely as a nasal decongestant in nonprescription products like Allerest, Dristan, Contac and Vicks Formula 44D, PPA is now used also in most diet aids, like Dexatrim and Control.

"We had discovered in the PPA literature an enormous amount of side-effects, which most people know nothing about," Vener points out. "One of the most life-threatening is hypertension. PPA may raise the blood

Continued on page 97

Motrin®
ibuprofen, Upjohn
600 mg Tablets

MOTRIN 600mg

More convenient for your patients.

Upjohn

©1984 The Upjohn Company

The Upjohn Company • Kalamazoo, Michigan 49001 USA

J-4044 January 1984

Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR.* The following is a brief summary.

* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K$^+$ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K$^+$ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

In Hypertension*… When You Need to Conserve K$^+$

Remember the Unique Red and White Capsule: Your Assurance of SK&F Quality

Serum K$^+$ and BUN should be checked periodically (s [illegible]

Potassium-Sparing

DYAZIDE®

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

Over 17 Years of Confidence

The unique
red and white
Dyazide® capsule:
Your assurance of
SK&F quality.

DYAZIDE
SKF

a product of
SK&F CO.
Carolina, P.R. 00630

©SK&F Co., 1983

pressure to the point where it can become a serious problem."

"We believe that PPA is a very dangerous drug which should only be used in prescription products, not over-the-counter products," Krupka says.

New hospital

Sinai Hospital of Detroit and Henry Ford Hospital plan to cooperatively establish an acute care, 200-bed hospital in West Bloomfield. The facility, not yet named, would be operated as a community hospital to serve the needs of residents in western Oakland County.

The proposed new facility would be located on HFH's Edsel B. Ford Center site. The 78-acre site already includes HFH's West Bloomfield Center for outpatient care and Maplegrove, center for treatment of the chemically dependent.

Developmental disabilities

The Wayne State University Board of Governors today approved the designation of the Wayne State University Developmental Disabilities Institute as a University Center.

The Developmental Disabilities Institute is an interdisciplinary program to coordinate patient and family services, professional training, consumer education, and clinical research in the area of developmental disabilities.

Funding comes from a $160,000 grant from the federal Administration on Developmental Disabilities, within the Department of Health and Human Services. Designated one of 36 national University Affiliated Facilities, the Institute is a state-wide resource.

Sanford N. Cohen, MD, associate dean and professor of pediatrics, has been named director of the Institute.

Cost containment

Butterworth Hospital, Grand Rapids, has been awarded $334,858 by the Kellogg Foundation to measure clinical practice behaviors to identify ways to contain and reduce health care costs.

Butterworth will begin by observing physicians' practice patterns for specific kinds of treatment. For each illness or injury, data will be collected on the length of time the patient is hospitalized, the number of tests and special procedures done, and hospital supplies used. The costs of these services and products will be recorded.

The information will then be compared among doctors within each institution and among the three facilities. Once the existing practice patterns have been defined, procedures will be drawn up to identify the best existing cost conscious practices and to develop new ones. These procedures will be presented to the medical staffs at each hospital.

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

1st FOR PROFESSIONAL PROTECTION EXCLUSIVELY

YOUR FIRST STEP TO FIRST QUALITY PROTECTION
CONTACT FIELD REPRESENTATIVES

Eastern Office
RICHARD K. WIND, JOHN K. GALLOWAY, THOMAS A. WEISMAN,
WAYNE M. BACKUS and MARK A. TISDEL
6785 Telegraph Road, Suite 350, Birmingham, Michigan 48010
(313) 647-6640

Western Office
GEORGE J. HAWORTH
2600 Five Mile Road, NE, Suite 101
Grand Rapids, Michigan 49505
(616) 361-0863

By Katharine S. Brown

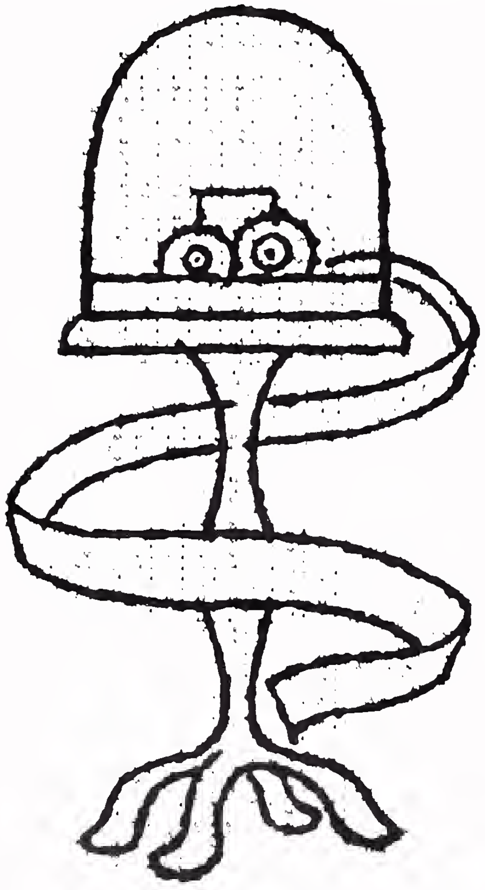
Thoughts for the beginning investor . . .

Perhaps you are just getting started in your practice and have no "investment" dollars, but want to plan ahead.

Perhaps you have a child or a spouse or a friend who is starting to invest.

Perhaps you now have "investment" dollars and have been letting them sit lazily in a money market account.

Do any of these situations fit you? Then here are a few thoughts.



Ms. Brown is an account executive with Prescott, Ball and Turben, investment banks and brokers, East Lansing. She is consultant to the MSMS Board of Managers on the investment of the MSMS capital and creative reserve funds assets.

Where should your assets be? If you have never done it, I urge you to list your assets. Be sure to include the lot in Florida and the gold coins in the lockbox. Make three groupings: (1) *Fixed assets,* like bonds, CDs and annuities; (2) *variable assets,* like stocks, real estate, and tax shelters; and (3) *cash equivalents,* like bank accounts and money market funds. Subtotal each grouping and calculate what percentage each is of the total. This process has an important purpose — it helps you to collect and monitor what you have.

How many dollars should you have in these categories? What should these allocation percentages be? As a general guideline, I usually suggest one-third fixed and two-thirds variable. However, this general rule should be modified by personal needs for income and liquidity, plus adjustments for the market. "Isn't two-thirds variable too risky?" you may ask. No, history has proven that the greatest capital appreciation will come through your variable investments — namely, stocks and real estate.

Some specifics

Let's take a look at the first category — fixed assets. Fixed rate investing — in CDs and taxable or tax-free bonds — requires you to look at the dates of maturity. I like to simplify fixed asset investing by focusing on one-to-five-year commitments with about the same dollar amount in each year. This creates a kind of "rolling maturity" schedule that tends to smooth out the impact of interest cycles because every year you have maturing investment able to be reinvested at current rates. When buying bonds, whether corporate or tax-free, be sure to emphasize quality in your portfolio.

"What about the third category — cash equivalents? How much should I keep in money market funds?" I believe a base amount equal to three to four months spending, plus any special expenditures known to be coming up, should be kept in a check writing money market fund.

And now to your variable assets — and specifically to the stock market.

"How do I know what stocks to buy?" Your first consideration should be diversification. Try to diversify into about 10 companies and, if possible, in as many different industries. Then when regarding individual stock selection consider these five key elements: (1) quality, (2) growth, (3) dividend payout, (4) debt ratio, and (5) value.

Take a look at the track record of a good stock mutual fund — it may astound you, and will definitely give you the diversification you need. I usually suggest mutual funds for the small investor or the large pension and profit sharing investor. It's a way of investing which offers diversification and superior performance and is usually cheaper.

If you want to build a portfolio on your own — without the professional management of a stock mutual fund, I offer the following suggestions.

Successfully investing in individual stock depends on a certain amount of careful planning, and a little luck. For example, no amount of planning would have enabled you to predict that Maryland Cup would be bought out by Fort Howard Paper or that Quaker Oats would pay $77 a share for Stokely-Van Camp. On the other hand, you can also be the victim of bad luck.

Some guidelines

People invest in the stock market, however, because by and large, the good luck tends to offset the bad and historically it is the vehicle where you can make the most money on your money.

It will pay you to set up a few guidelines so that you can avoid some of the pitfalls that lie ahead. To give you a headstart, I have formulated a few rules which may help.

1. Read a good book on the stock market, such as *The Intelligent Investor* by Benjamin Graham, *Your Investments* by C. Colburn Hardy or *The New Contrarian Investment Strategy* by David Dreman.
2. Spend some time reading such periodicals as *The Wall Street Journal, The New York Times, Forbes, Financial World, Barron's* and/or *Business Week.*
3. Pick a broker or investment counselor you can trust, and let them review your total asset picture.
4. Remember that only three percent of shareholders give serious attention to annual and quarterly reports. Make sure you're in this select three percent. It should help you out maneuver the apathetic 97 percent.
5. Don't put all your eggs in one basket, regardless of how sure you are that you have discovered the world's greatest investment. A good rule of thumb is to invest no more than 10 percent in any one industry. There are about 74 industries to choose from, so this should present no problem.
6. Don't over-diversify. You don't need to own 30 to 40 different stocks. For most investors, 10 to 20 is adequate. If each is in a different and unrelated industry, you should do all right.
7. Don't buy a stock unless you are willing to invest at least five percent of your assets in it. It makes no sense, for instance, to own 50 shares of Beatrice Foods in a $100,000 portfolio.
8. Don't be overly concerned with dividend income. For one thing, dividends are taxable as ordinary income. Capital gains are a far better deal in terms of taxes. (60 percent exclusion)
9. Be a patient investor. Invest for the long term. If a company is a leader in its field, it could be a sound holding for 10 or 15 years, not merely 10 or 15 weeks.
10. Don't be a nervous investor. If you buy a stock for $25, avoid the impulse to take short-term profits at $30. Above all, don't pay any attention to people who tell you that "you can't lose money by taking a profit." There's a significant tax advantage by establishing long-term capital gains. The reason I say this is simple: you don't win ballgames with singles and walks. You need a liberal sprinkling of doubles, triples and home runs.

Translated into the investment scene, this means you need your share of stocks that will double, triple or quadruple. If you are impatient and sell them when they are singles, you won't have any home runs, and you need home runs to cover up for the errors and strike outs. In every portfolio, there are bound to be some disappointments. *Perhaps as many as 30 percent of your selections will not measure up.*

11. Become familiar with financial terms and ratios which often appear in analysts' reports.
12. Don't be overly concerned with the price of a stock. Many investors, for instance, think IBM (at $120 share) is too expensive, since they can't afford 100 shares. What's wrong with owning 20 or 30 shares? Actually, IBM is *not* an expensive stock, relative to its quality, financial strength and marketing skill. Besides, IBM sells at only 14.8 times earnings. Many other high-tech stocks sell at 30 and 40 times earnings.

Don't worry

13. This brings us to the importance of the price/earnings ratio (sometimes call the multiple). It is calculated by dividing the earnings per share into the price of the stock. To illustrate, IBM earned $8.09 in the most recent 12-month period. Divide $8.09 into $120 and you get a P/E of 14.8, which is modestly above the level of stocks in general.

A great deal has been written about the importance of the P/E ratio. This concept is discussed in great detail by David Dreman in his excellent book, *The New Contrarian Investment Strategy.* He proves rather conclusively that low-multiple stocks — although you can point to many exceptions — out perform the high-multiple counterparts. This becomes particularly apparent in the weak market we have experienced this past summer. The ones that came crashing down were generally the high flyers, not the stodgy issues such as foods and utilities, which have P/E ratios that are well below the rest of the market.

14. Don't spend too much time worrying about what the market will do. This complex subject is best left to the professionals. As you may have already observed, these pros are not always right — nor do they always agree with one another. If you want to simplify your decisions, don't base your strategy on what you think the market will do over the next six months. *Instead, put your main emphasis on which stocks to buy for the long-term.*
15. When to sell is always a problem. If you tend to keep your stocks less than a year, you may be paying too much in taxes and commissions. By the same token, if you rarely make a trade, you are probably letting your garden grow up with weeds. A good rule of thumb is to sell your worst stock at least once or twice a year. Let's hope you can determine which one is the worst.

Good luck!

MSMS, MSMS/A, AMA, and medical assistants

March 7, 1984 — MSMS Board of Directors meeting, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

March 28-29, 1984 — Maternal Health Conference, Hyatt Regency Dearborn, contact: Katie Brewbaker, MSMS headquarters.

April 12, 1984 — Sports Medicine Conference, Long's of Lansing, contact: Mert Scholten, MSMS headquarters.

April 26-29, 1984 — Annual State Convention, American Association of Medical Assistants, Inc., Michigan State Society, Lansing Hilton Inn, contact: Caroline Rich, MSMS headquarters.

May 4-6, 1984 — MSMS House of Delegates Meeting, Amway Grand Plaza Hotel, Grand Rapids, contact Warren Tryloff, MSMS headquarters.

July 26-29, 1984 — Midsummer Meeting, MSMS Board of Directors, Deer Lake, Boyne Mountain, contact: Warren F. Tryloff, MSMS headquarters.

Sept. 19, 1984 — MSMS Board of Directors meeting, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Nov. 21, 1984 — MSMS Board of Directors meeting, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Other meetings

March 23, 1984 — "Creative Pain Management," Lansing General Hospital. Contact: Healthtrak (517) 377-8419.

April 2, 1984 — 63rd Annual Beaumont Lecture, John S. Najarian, MD, Minnesota, Speaker. Contact: Wayne County Medical Society headquarters.

April 12-15, 1984 — "Clinical Applications of Alcoholism Research," Westin Hotel, Renaissance Center, Detroit, contact: American Medical Society on Alcoholism, 733 Third Avenue, 14th Floor, New York, NY 10017 (212) 986-4433.

April 27, 1984 — "Empathic Listening: A Program for Clergy and Those Involved in Care for the Dying," Lansing General Hospital. Contact: Healthtrak (517) 377-8419.

June 7-9, 1984 — American Hospital Association 7th Annual Trustee Forum, Chicago. For program information, contact: B. Olsen, AHA, (312) 280-6301; for registration, contact: Division of Education (312) 280-6083.

June 14-15, 1984 — Michigan Chapter, American College of Surgeons Annual Meeting: Day 1, Resident Surgeons Day Competition; Day 2, Scientific Meetings. Grand Traverse Resort, Grand Traverse Village, contact: Viola M. Heins (517) 337-1351.

June 24-27, 1984 — National Environmental Health Association's Annual Educational Conference, Grand Rapids, contact: NEHA, 1200 Lincoln, #704, Denver, CO 80203 (313) 861-9090.

NEW MEMBERS

Karen S. Blackman, MD (FP)
230 Temple St.
Mason 48854

Frances C. Brokaw (Student)
422 S. Magnolia
Lansing 48912

I. Zachery Dyme, MD (PNP)
430 Cypress lane
East Lansing 48823

Judith L. Folkema, MD (P/CHP)
1676 Viewpond Dr.
Kentwood 49508

E. E. Font-Montgomery, MD
(Resident)
3578 Green Brier 337A
Ann Arbor 48105

Timothy D. Fritz, MD (IM/CD)
21 Michigan St., NE
Grand Rapids 49503

James C. Maher, MD (IM)
215 E. Mansion #101
Marshall 49068

Linda D. Norrell, MD (FP)
752 E. Hamilton Ave.
Flint 48505

Pravin C. Patel, MD (OM)
50 College Ave., SE
Grand Rapids 49503

Valerie Kay Pratt (Student)
4484 Karen Ann Dr. #G110
Okemos 48864

David M. Reifler, MD (OPH)
10639 Friske, NE
Rockford 49506

Andrew P. Saunders, MD (ORS)
770 Riverside Ave.
Adrian 49221

Anthony M. Sensoli (Student)
1115 Nielsen Ct. #5
Ann Arbor 48105

Denise A. Sinke (Student)
1447 Benjamin NE
Grand Rapids 49505

Randall J. Telman, MD (PS)
26 Sheldon Ave., SE
Grand Rapids 49503

Edwin C. Weathington, MD
(OBG)
2316 S. Cedar St.
Lansing 48910

Edward M. Wojtys, MD
(Resident)
11849 Fourt Lakes Dr.
South Lyon 48178

The AIDS Commitment

AIDS knows its business is serving physicians and their patients, who depend upon our dedication to deliver the best in diagnostic services.

AIDS ensures confidence by providing prompt, accurate and consistent testing services in a wide range of laboratory disciplines.

AIDS strives to conduct all business with integrity, skill and courtesy to each and every client.

AIDS intends to maintain excellence in skills and invest in research and development in order to better serve our clientele in the future.

AIDS understands that good service is the foundation of any business and the best service relies upon having the best people. Our staff of M.D.s, Ph.D.s, highly-skilled technologists and technicians, and AIDS' in-the-field PRO team assures the utmost in dependable, prompt, reliable service.

Allied Integrated Diagnostic Services (AIDS) is Michigan's fastest growing, most progressive full-service clinical laboratory. AIDS comprehensive diagnostic testing comprises a wide range of laboratory disciplines. We are ready to serve your laboratory needs 24 hours a day.

AIDS

ALLIED INTEGRATED DIAGNOSTIC SERVICES
22170 W. NINE MILE ROAD • SOUTHFIELD, MI 48034
313/352-5780

TOLL FREE NUMBER 1-800-AIDS LAB (243-7522)

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, (517) 337-1351.

Date: March 17-24, 1984, Aspen Conference on Emergencies in Medicine. Location: Aspen Conference Center, Continental Inn, Aspen, Colorado. **Sponsor:** Michigan Committee on Trauma, ACS; Michigan Society of Critical Care Medicine; Wayne State University School of Medicine. **Contact:** Theresa Sokol, WSU Department of Surgery, 4201 St. Antoine, Detroit 48201 (313) 577-5009. **Approved for:** 30 hours of Category I Credit.

Date: March 25, 1984, Arthritis, Collagen Disease and Immunology. Location: Holiday Inn, Mount Pleasant. **Sponsor:** Central Michigan Community Hospital, Continuing Medical Education Program. **For:** General practitioners, internists. **Contact:** Frank D. Johnson, MD, (517) 772-4846. **Approved for:** 7 hours of Category I Credit.

Date: April 9-11, 1984, Hemodynamic Monitoring. Location: Towsley Center, Ann Arbor. **Sponsor:** U-M Dept. of Pathology and Office of Continuing Medical Education. **Contact:** Office of CME, Towsley Center, Box 057, U-M Medical School, Ann Arbor, 48109, (313) 763-1400. **Approved for:** 14.5 hours of Category I Credit.

Date: April 12-13, 1984, Seventeenth Annual Cancer Symposium — Acute Leukemia. Location: Harper Hospital, 3990 John R, Detroit. **Sponsor:** WSU School of Medicine, Division of Oncology; Comprehensive Cancer Center of Metropolitan Detroit; and Harper-Grace Hospitals. **For:** Hematologists, oncologists, clinical pathologists, and those in basic sciences. **Contact:** WSU School of Medicine, Division of Continuing Medical Education, 4H University Health Center, 4201 St. Antoine, Detroit 48201. **Approved for:** 10.5 hours of Category I Credit.

Date: April 12-15, 1984, Tutorial on Myofascial Release Technique. Location: Kellogg Center for Continuing Education, MSU, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine. **For:** DOs and MDs. **Contact:** Sandy Kilbourn, A306 E. Fee, MSU-COM, East Lansing, 48824. **Approved for:** 24 hours of Category I Credit.

Date: April 16-20, 1984, Spring Family Practice Review Course. Location: Towsley Center, Ann Arbor. **Sponsor:** Office of CME, U-M Medical School. **Contact:** Office of CME, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 35 hours of Category I Credit.

Date: April 25-26, 1984, What's New and Practical in Critical Care. Location: Michigan Inn, Southfield. **Sponsors:** Michigan Committee on Trauma, ACS; WSU School of Medicine; Michigan Society of Critical Care Medicine. **Contact:** Theresa School, WSU Department of Surgery, 6-C UHC, 4201 St. Antoine, Detroit 48201 (313) 577-5009. **Approved for:** 12 hours of Category I Credit.

Continued on page 104

How to reduce your accounts receivable without lifting a finger.

If your accounts receivable look like the National Debt, don't blame the economy entirely. Your billing system might be part of the problem. Late statements mean late collections. Error-prone or ambiguous statements collect complaints instead of cash.

The Control-o-fax Statement Service eliminates these problems. This service gets your billing out on time every time. And each statement is the exact "picture" copy of your ledger card.

Our Control-o-fax Statement Service clients have reduced their accounts receivable significantly without lifting a finger. Call for full details.

Detroit Area:
Creative Systems, Inc.
19675 W. Ten Mile Rd.
Southfield, MI 48075
(313) 352-9425

Control-o-fax
STATEMENT SERVICE

Outstate Michigan:
Reed Office Systems, Inc.
2121 Three Mile Road, N.W.
Grand Rapids, MI 49504
(616) 784-4755
LANSING 482-0200 FLINT 238-7447
TRAVERSE CITY 941-7771
SAGINAW 752-8802

turbo
esprit

Improve your circulation.

A direct descendant of the legendary road racers that hold seven Grand Prix championships on four continents, the Lotus Turbo Esprit quickly becomes an affair of the heart.

It handles, responds and performs like no other production sports car on Earth, and its 16-valve, turbocharged inboard-mounted engine makes this astonishing car the most pulse-quickening way yet to announce your arrival in all the right circles.

But don't put it off for long. Very few Americans will have the opportunity to own a Lotus Turbo Esprit. It's a strictly limited edition, and at $50,000, it's clearly not for newcomers.

If you think the Lotus Turbo Esprit could improve *your* circulation, examine one soon at Birmingham, Motors, Ltd. A fully qualified staff is standing by to assist.

LOTUS

BIRMINGHAM MOTORS, LTD.

479 S. Woodward, Birmingham MI 48011 (313) 646·3980

Date: April 25-26, 1984, The Carotid and The Eye. Location: Pontchartrain Hotel, Detroit. **Sponsor:** Harper-Grace Hospitals, Kresge Eye Institute, WSU Department of Surgery and Ophthalmology. **For:** Ophthalmologists, neurologists, vascular and neurological surgeons. **Contact:** WSU School of Medicine, Division of CME, 4H, UHC, 4201 St. Antoine, Detroit 48201 (313) 577-1180. **Approved for:** 9.5 hours of Category I Credit.

Date: May 5-9, 1984, Advanced Muscle Energy Tutorial (below diaphragm). Location: Kellogg Center for Continuing Education, East Lansing. **Sponsors:** Michigan State University College of Osteopathic Medicine and College of Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

Date: May 11, 1984, Regional Associates Meeting, American College of Physicians. Location: Sheraton Oaks Hotel, Novi. **Sponsor:** American College of Physicians. **Contact:** Arnold R. Axelrod, FACP, Sinai Hospital, 6767 W. Outer Drive, Detroit 48235. **Approved for:** 4 hours of Category I Credit.

Date: May 14-18, 1984, Advances in Internal Medicine. Location: Towsley Center, Ann Arbor. **Sponsor:** Office of CME, U-M Medical School. **Contact:** Office of CME, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 34 hours of Category I Credit.

Date: May 17, 1984, Perinatal Horizons. Location: Western Michigan University, Kalamazoo. **Sponsor:** Southwestern Michigan Perinatal Association. **Contact:** Marilyn Potgiesser, RN, Educational Services Instructor, Bronson Methodist Hospital, 252 East Lovell Street, Kalamazoo 49007 (616) 383-6405. **Approved for:** 6 hours of Category I Credit.

Date: May 18-19, 1984, 27th Annual Clinic Days: Transfusion and Infusion Therapy in Pediatrics — Current Concepts. Location: Children's Hospital of Michigan, Detroit. **Sponsor:** CME Department, Children's Hospital of Michigan. **Contact:** CME Department, Children's Hospital of Michigan, 3901 Beaubien Blvd., Detroit 48201 (313) 494-5455. **Approved for:** 10 hours of Category I Credit.

Date: June 11-15, 1984, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsors:** MSU Colleges of Osteopathic Medicine and Human Medicine, and the North American Academy of Manipulative Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

Date: June 24-29, 1984, 20th Annual Northern Michigan Summer Conference: An Update on Common Clinical Concerns. Location: Hilton Shanty Creek, Bellaire. **Sponsor:** U-M Office of Continuing Medical Education. **Contact:** Office of CME, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 20 hours of Category I Credit.

Date: July 26-27, 1984, Coller Penberthy Thirlby Medical Conference. Location: Park Place Hotel, Traverse City. **Sponsor:** Munson Medical Center. **For:** All interested physicians. **Contact:** Norma Powers, Coordinator of Medical Education, Munson Medical Center, 6th and Madison Streets, Traverse City 49684 (616) 922-9544. **Approved for:** 9 hours of Category I Credit.

Date: August 13-17, 1984, Tutorial on Direction Action Thrust Manipulative Therapy. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU College of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

TAKE A BREAK EACH WEDNESDAY

with **Health Care News**, the most accurate, reliable, and complete way to keep abreast of health care regulations, legislation, mergers, moves, negotiations, people, continuing education, and job opportunities. We give you the news you need to know **52 times a year for only $11. $20 for 2 years & a free coffee cup.**

Health Care News
Your FREE HCN Coffee Cup!

Health Care News

SERVING MICHIGAN'S HEALTH CARE PROFESSIONALS

Subscribe now. Limited time only.

☐ Payment Enclosed Firm Name (if applicable)________________
☐ New Name ________________
☐ Renewal Address________________
☐ Bill me—$1.50 additional City/State/Zip ________________
Interbank #____________ Exp. Date ________
☐ Bill firm—$1.50 additional Signature________________
☐ Visa ☐ Mastercard Drivers License Number ________________

5440 Cass Avenue • Detroit, Michigan 48202 • (Phone (313) 831-3323
Telephone Orders Accepted

TAKE THE HEADACHE OUT OF YOUR PRACTICE!

℞ MICHIGAN HEALTH BILLING & COLLECTION SERVICE

We are a company dealing exclusively with physician's billing and collection.

- Guarantee 99% collection
- Fully computerized
- Competitive fees
- Same day billing
- Our fee is based on the amount collected *not* on the amount billed

Michigan Health Billing & Collection Service has the experience and expertise to properly bill and collect more dollars for you. We urge you to compare your costs with ours.

WE CAN HELP!

Please call or write:

MICHIGAN HEALTH BILLING & COLLECTION SERVICE
MAIN OFFICE
603 West Michigan Avenue, Jackson, Michigan 49201
(517) 787-6440
(313) 995-8885

For 517 Area Code: 1-800-227-2279

The rate for each classified advertisement in *Michigan Medicine* is 20¢ per word, with a minimum charge of $10.00. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

Positions Open

PRIMARY CARE PHYSICIANS needed for multi-specialty clinic with family practice base. Need primary care general practice internists and general surgeons. Reply with CV to — Administrator, Redford Medical Center, 25210 Grand River, Detroit, MI 48240.

LANSING: FULL TIME EMERGENCY PHYSICIAN WANTED to complete five man group at 280 bed hospital. Fee for Service with Excellent remuneration. Contact Director, Emergency Department, St. Lawrence Hospital, 1210 W. Saginaw, Lansing, Michigan 48915.

SECOND YEAR POSITION AVAILABLE in Midland family practice residency program for July, 1984. Inquiries welcome. Contact: Robert J. Lachance, MD, Director, Midland Hospital Center, Family Practice Residency, Midland, Michigan 48640.

MEDICAL RESEARCH ASSISTANT WANTED to compile data on patients and analyze the effects of interferon treatments. Will record and monitor side effects of treatment, its effect on patients and make recommendations on the further use of and the efficacy of the treatment. Will prepare and publish results of medical research in journals. Requires MD Degree and one year of experience as a physician. 40 hours per week, $18,400.00 per year. Send resumés to Michigan Employment Security Commission, 7310 Woodward Avenue, Room 415, Detroit, Michigan 48202. Reference Number 28683.

PHYSICIAN (MD or DO) TO WORK PART TIME in a plasma donor center. Contact Jamie Sielatycki, American Plasma Management, Inc., 705 North Park St., Kalamazoo,m MI 49007 (616) 381-0086.

NEW CLINIC OPENING — Position for Family Practice or General Internist. Eight locations. Complete out-patient facilities at multiple locations. Liberal salary, full benefits and physician does his own hospital billing. Call Mary at (313) 921-8080 for appointment.

UNUSUALLY COMPETENT NUCLEAR RADIOLOGIST wishes to relocate to a lakeside community. Send inquiries to Post Office Box 293, Palos Heights, Illinois 60463.

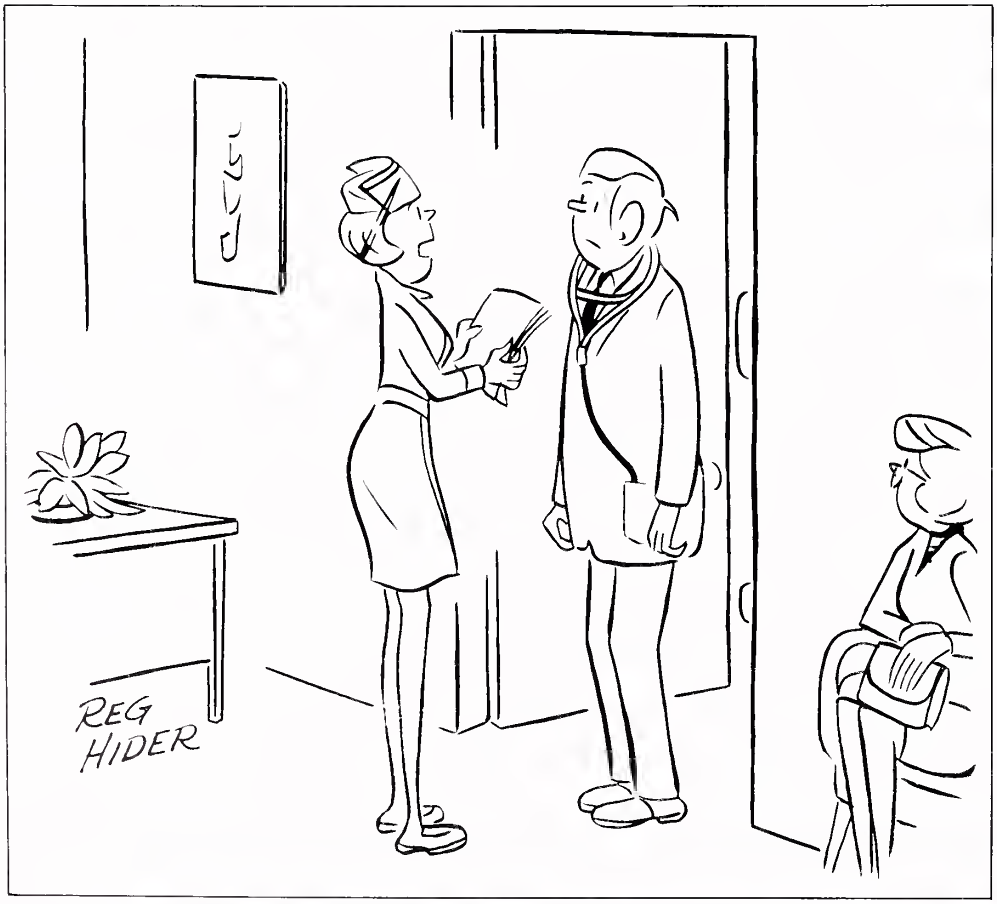
PHYSICIANS SEEKING ADMINISTRATIVE OR RESEARCH POSITIONS in the pharmaceutical industry are invited to contact Medical Placement Associates. We have been commissioned by several pharmaceutical firms to assist in locating specialists in cardiology, psychiatry, neurology, obstetrics/gynecology, infectious diseases, and administrative medicine. For further particulars, please forward your curriculum vitae to Medical Placement Associates, 18877 West Ten Mile Road, Suite 100, Southfield, Michigan 48075, or call (313) 557-3350.

POSITIONS WITH THE STATE OF MICHIGAN — Currently taking applications for positions expected to be available in the future. Office locations now include Kalamazoo, Lansing, Southfield, and Traverse City. A board certified or board eligible psychiatrist needed for the Kalamazoo office, and internists with rheumatology or cardiology background desired for other offices. Beginning salary in low 60s with approximately 26% fringe benefits. An equal opportunity employer. All inquiries treated confidentially. For further details, please write: Harry D. Nesmith, MD, Chief Medical Consultant, Disability Determination Service, PO Box 30011, Lansing, Michigan 48909.

MEDICAL RESEARCH ASSISTANT in Internal Medicine wanted to compile data on patients and analyze the relationship between seizure peripheral vascular disease and well controlled blood sugars in patients with diabetes; will analyze reduction methods using different dietary, medical and surgical techniques in obese people; and rehabilitation of post-miocardio infarction and congestive heart failure patients. Will prepare and publish results of medical research in journals. Requires M.D. Degree and one year related experience as Primary Care Physician. 40 hours per week, $19,200.00 per year. Contact Michigan Employment Security Commission, 7310 Woodward Avenue, Room 413, Detroit, MI 48202, Ref. No. 40983.

FAMILY PHYSICIAN — Needed immediately to join a well-established family practice in thoroughly equipped office. Excellent financial opportunity in Alpena, Michigan, a friendly town on beautiful Lake Huron. 135-bed hospital is completing expansion and renovation project. Contact James Mazrum, JD, (517) 356-3444, 109 Chisholm St., Alpena, Michigan 49707.

FAMILY PRACTICE (BATTLE CREEK) — Two man family practice seeking one or two physicians doing over $400,000 gross yearly. Serving area of 100,000 with three open hospitals. Salary first year. Full partner after one year. Health insurance, disability insurance, pension and profit sharing plans, six weeks vacation. Inquire to Cinde VanDusen, Capital Avenue Medical, PC,



"Want me to run through your shriekingly hectic schedule for today?"

WHY AMA?

The AMA has taken an important initiative in combating prescription drug abuse. An informal steering committee organized by the AMA has developed a data analysis system that would help states detect sources of prescription drug diversion. Cracking down on prescription drug abuse: it's one more good reason why you should be part of the AMA.

To Join,
Contact your county or state medical society or write: Division of Membership, AMA, 535 North Dearborn Street, Chicago, Illinois 60610 or call collect, (312) 751-6196.

AMA
AMERICAN MEDICAL ASSOCIATION

719 Capital Avenue SW, Battle Creek, MI 49015. Phone (616) 965-5188 (9am-5pm).

WANTED: ANESTHESIOLOGIST FOR 7 (seven) man group (PC) of Boardeligible or certified anesthesiologists employing 8 (eight) CRNA's. We practice in 2 (two) hospitals with a total capacity of 600-700 beds. All specialty modalities are represented in the community. No routine obstetric coverage. LOCATION — Muskegon, Michigan, situated on Lake Michigan and several inland lakes providing ample opportunity for all nautical, pictorial pursuits and other outdoor activities. If interested, please write to: A.M. Chiasson, MD, 1060 W. Norton Ave., Muskegon, MI 49441.

GENERAL INTERNISTS AND FAMILY PRACTITIONERS interested in geriatric medicine will find an optimal practice setting in our Sun City, AZ healthcare centers. CIGNA Healthplan, Inc., one of the nation's largest prepaid health plans, offers an opportunity to practice medicine free of the business aspects. Night and weekend call is very light. Competitive salaries. Excellent benefits. Please respond to: Director, Professional Recruitment, PO Box 29030, Phoenix, AZ 85038 (602) 954-3506.

ENJOY THE NORTHWOODS! Need an aggressive, hardworking Internal Medicine Specialist and a Family Practice Specialist to join a brand new clinic in Eagle River, Wisconsin. Great income potential and outstanding fringe benefit packages available. For further information call collect (715) 842-3202, or write to Administrator, 2409 N. 13th, Wausau, Wisconsin 54401.

ANESTHESIOLOGIST: Board Certified or Eligible to join CRNA as Chief in a JCAH approved 129-bed hospital in Northern Michigan four-season vacationland. Excellent schools and quality of life. Live on Lake Huron or one of our large inland lakes and be only minutes from the Hospital. Financial arrangements open to discussion. Send c.v. to D. Spedding, Community Memorial Hospital, Box 419, Cheboygan, MI 49721.

OB/GYN, ENT, Ophthalmologist, Urologist, Pediatrician in Virginia; excellent place to practice; coverage population of 40 to 50 thousand; minimum guarantee; excellent weather; sixty miles south of Richmond; near ocean. Send CV to Administrator, Greensville Memorial Hospital, 214 Weaver Avenue, Emporia, Virginia 23847 or call 804/348-2000.

FAMILY PHYSICIAN: IMMEDIATE OPENING for a residency trained FPpreferring small-town life style and interested in "whole person medicine from the Christian perspective" in a new office in the small college town of Hillsdale in southern Michigan. Write or call: Frederick L. Bean, MD, Hillsdale Family Practice, 111 South Howell, Hillsdale, Michigan 49242, (517) 437-7307.

UROLOGIST NEEDED — to join extremely active one-man practice in the four-season vacationland of Northern Lower Michigan. Associate is necessary to share existing workload and to adequately cover our expanded service area. Salary guarantee and fringe benefit package available. If interested, send c.v. to David Spedding, Assistant VP, Community Memorial Hospital, Cheboygan, MI 49721.

SOUTHERN CALIFORNIA — We are seeking experienced specialists and general practitioners for our facilities in Los Angeles and Orange Counties. Located in close proximity to major teaching centers, we offer the opportunity of continued professional development and rewarding clinical practice in association with 350 full time physicians. Compensation and benefits are excellent including paid vacation, educational leave, sick leave, and retirement; insurances included are malpractice, life, disability, medical and dental. Send CV to: Director/Physician Recruitment, CIGNA Healthplans of California, 700 N. Brand Blvd., Suite 500-M, Glendale, CA 91203.

FAMILY PHYSICIANS: Needed to locate in and provide medical care at satellite clinic in three northern Michigan resort communities within our service area. Salary guarantee, vacation, educational leave and fringes provided. Coverage assured and no initial investment required. Call or send current c.v. to: David H. Spedding, Community Memorial Hospital, Box 419, Cheboygan, MI 49721 (616) 627-1201.

Miscellaneous

HOWELL, MICHIGAN — Two suites available in attractively designed medical-dental building. Complex conveniently located walking distance of hospital which serves fastest growing county in the state. Unlimited opportunity for hardworking family practitioner looking to establish large practice. For information, call (517) 546-7630.

1984 CME CRUISE/CONFERENCES ON LEGAL-MEDICAL ISSUES — Caribbean, Mexican, Hawaiian, Alaskan, Mediterranean. 7-14 days in Winter, Spring, Summer. Approved for 18-24 CME Cat. 1 credits (AMA/PRA). Distinguished professors. FLY ROUNDTRIP FREE ON CARIBBEAN, MEXICAN & ALASKAN CRUISES. Excellent group fares on finest ships. Registration limited. Pre-scheduled in compliance with present IRS requirements. Information: International Conferences, 189 Lodge Ave., Huntington Station, N.Y. 11746. (516) 549-0869.

Rx PADS PRINTED to your specifications. $20.00 per thousand in pads of 100. $21.00 one time set up charge. Shipping additional. Smallcraft Printing Company, 211 E. Kalamazoo St., Lansing, MI 48933 (517) 485-0553.

EXCELLENT USED MEDICAL EQUIPMENT: Picker 300 Milliamp Radiographic & Fluoroscopic X-ray apparatus complete with Image Intensification, Kodak Processor, Surgery Lights, Surgery Tables, EKG, Ritter Table, Lab, Therapy/Rehab. Equipment, etc. All reasonably priced. Certified appraisals by certified appraiser for hospital, business, court use. Box #37214, Oak Park, Michigan 48237 (313) 342-5484.

MIDWEST PAIN SOCIETY 8TH ANNUAL SCIENTIFIC MEETING, "PRACTICAL MANAGEMENT OF COMMON PAIN SYNDROMES," March 16-17, 1984, Westin-Crown Center Hotel, Kansas City, MO. Guest Speaker: Jes Olesen, MD, Hellerup, Denmark. Contact Jan Johnston, Office of C.E., Univ. of Kansas Medical Center, Rainbow at Olathe, Kansas City, KS 66103. (913) 588-4480.

SPORTS MEDICINE: REHABILITATION OF THE INJURED ATHLETE, March 15-1984, Westin-Crown Center Hotel, Kansas City, MO. Guest Speakers: Barbara J. DeLateur, MD, Univ. of Washington-Seattle, and James H. McMaster, MD, Univ. of Pittsburgh. Contact Jan Johnston, Office of C.E., Univ. of Kansas Medical Center, Rainbow at Olathe, Kansas City, KS 66103. (913) 588-4480.

PRACTICE TO BUY OR SELL? Practice brokerage is our only business. Statewide service. CALL MICHIGAN PRACTICE BROKERAGE CORPORATION. (313) 827-8874.

DOCTOR, YOU CAN'T BEAT THE QUALITY OR THE PRICE! Holter Monitor scanning service. Physician owned, trained and supervised. $35.00 for cassette reports; $45.00 for reel to reel reports; no contracts to sign. We can arrange for lease/purchase of holter equipment. Why are you paying more and getting less? DCG Interpretation (313) 879-8860.

VIRGIN ISLAND CONDOMINIUM in St. Thomas for rent. Two bedrooms; 25 foot balcony directly on the ocean. Three pools, tennis courts, gorgeous beach and duty-free shopping. List of medical meetings available. Reduced air fares. $180.00 per night, 12-15-83 to 4-15-84; $100.00 per night, 4-15-84 to 12-15-84. Call Dr. Marshall collect at (313) 478-2739, days or (313) 471-7070, nights.

PROFESSIONAL RESUME SERVICES, 1125 South Cedar Crest Boulevard, Allentown, Pennsylvania 18103. We provide resume preparation for physicians. All specialties. Prompt and confidential. Call or write for information. (215) 433-4112.

ATTENTION DOCTORS: We have previously owned medical, laboratory, office and x-ray equipment in excellent condition. We buy, sell, trade, move and repair. Office appraisals available by certified surgical consultants. Call Doctor Medical Resale at 313-569-4407, 9 am-9 pm.

LEASE MEDICAL EQUIPMENT — You select. $2,000 to $100,000. Why tie up cash or credit? Call for quote. Medical Leasing Co. 313-879-8860.

PHYSICIANS SIGNATURE LOANS TO $50,000. Up to 7 years to repay. No repayment penalties. Prompt, courteous service. Competitive fixed rate, with no points, fees or charges of any kind. Physicians Service Association, Atlanta, GA. Toll-free (800) 241-6905.

Thanks to our advertisers

AIDS	101
AMRC	93
Birmingham Motors	103
Boots Pharmaceutical	76-78
Brown Pharmaceutical	55
Burroughs-Wellcome	59
Detroit-Macomb Hospital Assn.	87
Health Care News	104
Lab of Clinical Medicine	80
Lilly	71
Mandell, Sanford, CPA	92
MDPAC	69
Medical Protective	97
Michigan Conference on Maternal Health	IFC
Michigan Health Billing	105
MPMLC	64-65
MSMS Sports Medicine Conference	69
Naples Research & Counseling Center	81
Oakland Health Education Program	79
Pfizer	74-75
Phoenix Baptist Hospital	88
PICOM	85
Program to Assist Impaired Physicians	86
PSG/GTE MINET	73
Reed Office Systems	102
Roche	OBC, BC
Roerig	60-62
Smith, Kline & French	96
Stratton-Cheeseman	89
Upjohn	95

Malpractice: Where do we go from here?

With the Michigan legislature immobilized by "recall fever," it is becoming increasingly apparent that little or no action will be taken in the foreseeable future on the MSMS package of medical malpractice reforms — Senate Bill 224.

SB 224 was introduced in May, 1983 by Senator Patrick McCollough, who now faces recall for voting for Governor Blanchard's "temporary" 38% tax hike last spring.

Since its introduction, SB 224 has seen little action. Private negotiations between representatives of MSMS and the Michigan Bar ended late last year in failure, with the Bar conceding very little and demanding mandatory malpractice insurance.

Further, an objective and comprehensive review of what has been accomplished in the other 49 states since the malpractice "crisis" first developed gives us little encouragement.

For a short time, malpractice reform legislation in states like Indiana, Florida, Texas, and Arizona seemed promising. Over a longer period of time, however, even these "reform" efforts did little to stem the tide of increasing numbers of suits filed, increasing amounts of awards, and increasing size of premiums.

Almost out of desperation, it seems, a Grosse Pointe Shores physician's wife recently announced a new service of supplying subscribing physicians with help in screening potential high risk patients with a history of having initiated past litigation in Wayne, Oakland, or Macomb counties.

Louis R. Zako, MD
MSMS President-elect

Additionally, we have seen a growing trend nationwide of obstetricians giving up obstetrics because of the increasingly intolerable risk. What will our colleagues do when they have to give up gynecology as well, for the same reason? More importantly, what will society at large do?

Perhaps it is time to admit that "reform" of the present tort system of dealing with alleged medical malpractice by approximately one out of every four physicians cannot possibly lead to true reform because the system itself is fatally flawed.

Perhaps now is the time for other elements of society — business, labor, senior citizen groups, hospitals, the insurance industry, and other interested and involved groups in the private sector — to work together to find a solution to a major social problem.

Whether some variation on a no-fault system, mandatory and binding arbitration, or some other alternative to the current chaotic, unjust, and exceedingly expensive (for society at large) method of resolving malpractice allegations is the preferable approach.

I am not prepared to say. I am prepared to say, nonetheless, that while the present situation is becoming increasingly intolerable to physicians, emotionally and financially, the ultimate penalty is being paid by patients. The price not only is the tremendous waste of "defensive" medicine, but also more importantly, the growing alienation between patient and physician and the greater reluctance of physicians to treat difficult and risky conditions. It is truly a sad day for all of us, patients and physicians, when a significant number of us find it too risky from a medicolegal standpoint to continue delivering babies.

And this, at a time when physicians are trained to do the task more safely than at any other time in history!

Doctor Zako, a Dearborn Heights family physician, writes this month at the invitation of MSMS President Donald K. Crandall, MD, Muskegon. Doctor Zako will be installed May 5 at the MSMS House of Delegates meeting in Grand Rapids.

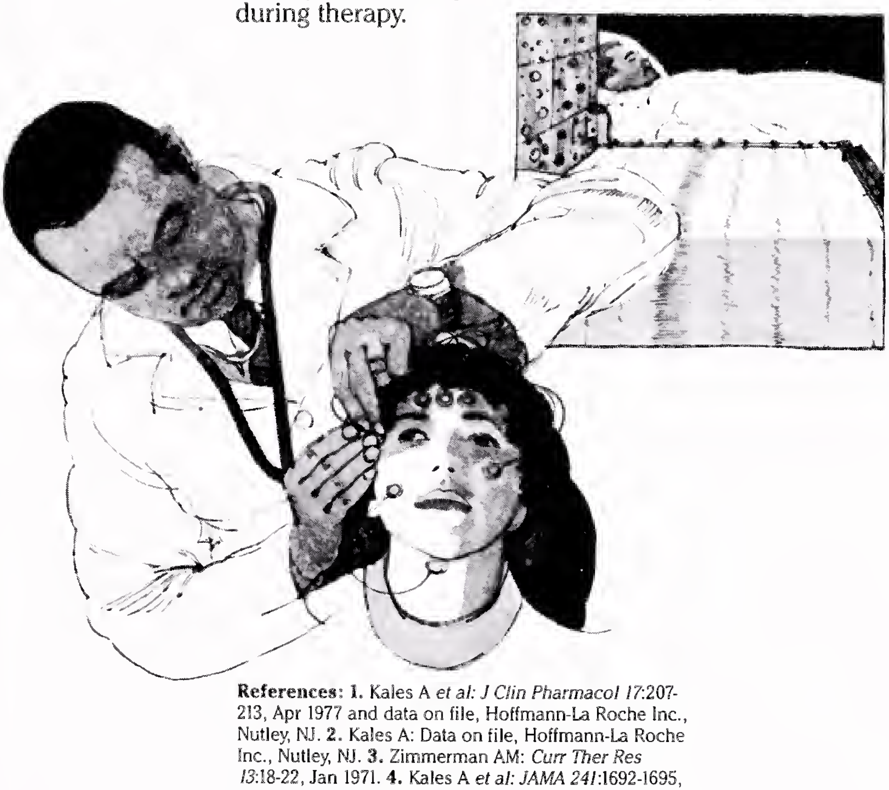
The weight of objective evidence supports the clinical efficacy of

Dalmane® Ⓒ

flurazepam HCl/Roche

15-mg/30-mg capsules

- Studied extensively in the sleep laboratory—the most valid environment for measuring hypnotic efficacy.[1-12]
- Studied in over 200 clinical trials involving over 10,000 patients.[13]
- During long-term therapy, which is seldom required, periodic blood, kidney and liver function tests should be performed.
- Contraindicated in patients who are pregnant or hypersensitive to flurazepam.
- Caution patients about drinking alcohol, driving or operating hazardous machinery during therapy.



References: **1.** Kales A *et al: J Clin Pharmacol 17*:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. **2.** Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **3.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **4.** Kales A *et al: JAMA 241*:1692-1695, Apr 20, 1979. **5.** Kales A, Scharf MB, Kales JD: *Science 201*:1039-1041, Sep 15, 1978. **6.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **7.** Kales A, Kales JD: *Pharmacol Physicians 4*:1-6, Sep 1970. **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **9.** Dement WC *et al: Behav Med 5*:25-31, Oct 1978. **10.** Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **11.** Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. **12.** Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. **13.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

Dalmane® Ⓒ
(flurazepam HCl/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

Contemporary Hypnotic Therapy

Dalmane® [flurazepam HCl/Roche] Stands Apart

225 000000000 123184
SERIALS DEPT - LIBRARY
COLLEGE OF PHYS OF PHILA
19 SOUTH 22ND STREET
PHILADELPHIA, PA 19103

Only one sleep medication objectively fulfills all these important criteria:

- Rapid onset of sleep.[1]
- More total sleep time on the first 3 nights of therapy.[1]
- More total sleep time on nights 12 to 14 of therapy.[1]
- Continued efficacy for at least 28 nights.[2]
- Seldom produces morning hangover.[3]
- Avoids rebound insomnia when therapy is discontinued.[1,4,5]

15-mg/30-mg capsules

Dalmane® Ⓘⓥ
flurazepam HCl/Roche

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

Copyright © 1984 by Roche Products Inc. All rights reserved.

Please see summary of product information on reverse side.

STACKS

MICHIGAN MEDICINE

March 1984 JOURNAL OF THE MICHIGAN EDICAL SOCIETY Volume 83, Number 13

OF THE
LLEGE OF PHYSICI
OF PHILADELPH
APR 3 - 198

The new Board of Medicine

Plan to attend this CME event!

1984 MSMS Sports Medicine Conference

Long's Convention Center
Lansing, Michigan
Thursday, April 12, 1984

MSMS members, college and high school coaches, trainers and others with an interest in the care of athletes and their injuries, are invited to attend the 1984 MSMS Sports Medicine Conference Thursday, April 12.

Featured guest clinician will be William Clancy, MD, orthopedic surgeon and team physician for the University of Wisconsin, Madison. Doctor Clancy, back by popular demand after an appearance here several years ago, will offer two presentations related to knee injuries. Other speakers are physicians from high school, college and pro level ranks.

The MSMS Committee on CME Programming, an organization accredited by the MSMS Committee on CME Accreditation, certifies that this activity meets the criteria for a maximum of 6 credit hours in Category I toward the requirements for Michigan relicensure and of the Physician Recognition Award of the AMA, provided it is completed as designed.

The program

8-8:50 a.m.	Registration
8:50-9 a.m.	Welcome, opening comments
9-9:30 a.m.	Office Examination of the Acutely Injured Knee
9:30-10 a.m.	Current Problems in Head and Neck Protection in Football
10-10:15 a.m.	Coffee Break
10:15-10:45 a.m.	Diagnosis and Early Treatment of Ankle Injuries
10:45-11:15 a.m.	Throwing Injuries to the Shoulder and Arm
11:15-11:45 a.m.	Panel Discussion on Sports Injuries (Q & A Session)
11:45-1 p.m.	Luncheon
1-1:30 p.m.	Thoughts on Being a Team Physician
1:30-2 p.m.	Non-Operative and Functional Rehabilitation of 1st, 2nd and 3rd Degree Isolated Medial-Collateral Knee Injuries
2-2:30 p.m.	Injuries to the Female Athlete
2:30-2:45 p.m.	Refreshment Break
2:45-3:15 p.m.	Overuse Syndromes in the Athlete
3:15-3:45 p.m.	Strength in Sports
3:45-4:15 p.m.	Diagnosis and Early Treatment of Hand Injuries in Athletes
4:15-4:45 p.m.	Panel Discussion and Review of Afternoon Presentations

Return this completed registration form to MSMS, Post Office Box 950, East Lansing, MI 48823, Attention: Sports Medicine Conference.

Name ______________________________

Address ______________________________

City ____________________ **State** __________ **Zip** ________

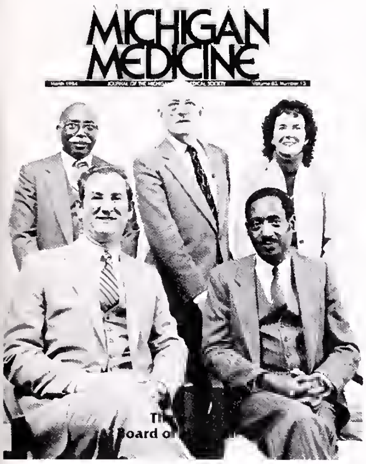
Please check: ____ **MD/DO** ____ **Coach** ____ **Trainer**

____ **Specialty** ____ **Resident** ____ **Med. Student** ____ **Other**

Registration fee is $30 for physicians, $20 for all others. Fee includes luncheon, coffee breaks, handout materials and registration costs. Payment with registration is necessary.

March 1984, Vol. 83, No. 13

MICHIGAN MEDICINE



About the cover

The Michigan Board of Medicine is regrouping under new chairman James L. Fenton, MD, Bay City, seated left. 1983 Board members continuing their service in 1984 posed with Doctor Fenton recently for our photographer. At Doctor Fenton's left is Charles Vincent, MD, Detroit. From left, standing, are Addison Prince, MD, Detroit; John Fennessey, MD, Detroit, and Karen Kotch, MD, West Bloomfield. A continuing member who was not present for the photo is Henry Kallet, MD, Ann Arbor. New members are introduced inside. **Photo by Kim Kauffman.**

SPECIAL REPORT

112 The Michigan Board of Medicine has a new president, seven new members and a new charge — to improve its efficiency and strength. MSMS is working with the Board on this important mission, and both are being assisted by the cooperative head of the Michigan Department of Licensing and Regulation. One of the goals of all is immunity of board members from lawsuits as a product of their official duties. Another is better allocation of state funds for board work. For full discussion of these issues, as well as profiles of new board members, turn to the pages of this month's special report; James L. Fenton, MD; Frederick W. Minkow, MD; C. William Howe and Catherine A. Rosario

FEATURES

123 MSMS House of Delegates to act on formation of the new MSMS Hospital Medical Staff Section; Gary D. Maynard, MD

132 Update on MSMS study of closed malpractice claims; Deborah Zannoth

136 The report of the evaluation committee to the Michigan Medical Arbitration System; Rhoda M. Powsner, MD, JD

DEPARTMENTS

110 In my opinion; Robert E. Paxton, MD

111 Letters

118 Board of Medicine actions

143 MSMS/A; Clarice James and Cathie L. Martin

144 Deaths

151 Meetings

152 Category I meetings

156 Classified ads

157 Ad index

158 President's page; Thomas R. Berglund, MD

Join MSMS today and keep medicine strong!

By Robert E. Paxton, MD

Receipt of 1984 MSMS dues payments are lagging behind 1983. As Finance Committee chairman, that concerns me. And it affects us all.

Many members have cited the still weak Michigan economy and sluggish practice cash flows in explaining their tardy payments. For that very reason, MSMS has a flexible installment dues payment plan available.

Original payment due dates were January 12 and March 12. Though these dates have passed, installment advantages may still be realized by paying half of the billed dues immediately and the balance in 60 days.

The goal, of course, is to not allow your membership to lapse. MSMS-provided services and representation for Michigan physicians require continued support of every current member — and then some.

Current members also can greatly assist membership recruitment efforts. Encourage non-members to join our county, state and AMA federation of organized medicine. Many things we can accomplish working together, we cannot do alone. Things like Washington and Lansing lobbying efforts. And qualifying for group rate insurance programs or easily remaining up-to-date on medical and political developments.

MSMS has more than 10,000 members. Let's work to better that. Membership applications are available at your county society or MSMS headquarters. Remember, belonging keeps our profession strong!

Doctor Paxton is a Fremont family physician and member of the MSMS Board of Directors.

Michigan State Medical Society
Warren F. Tryloff, director

Committee on Publications
Busharat Ahmad, MD, Marquette, chairman
Harvey Andre, MD, Grand Rapids
Vickers C. Hansen, MD, Manistee
Leland E. Holly II, MD, Muskegon
James H. Tisdel, MD, Port Huron

Editor
Judith Marr

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

MICHIGAN MEDICINE (ISSN 0026-2293) is the official journal of the Michigan State Medical Society, published under the direction of the Publications Committee. Published five times a month, 60 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $30.00; single copies, $1.50. Additional postage: Canada, $1 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to articles, news, exchanges, should be addressed to Judith Marr, advertising inquiries to Joyce Crum and address changes to Peg Berry, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517-337-1351.

©1984 Michigan State Medical Society

Nuclear war

In response to Doctor Gerald Drake's view in the January, 1984 *Michigan Medicine,* I want to join the chorus and add:

It's time we all, as people, stop concentrating on our own near and clear concerns and open our eyes to see how we're rushing toward the nuclear abyss.

It's time to learn to look for and respond to the common strands we share with people all over the world.

It's time we recognize that, even if The Bomb isn't dropped, it's going to sap this world of all its vitality and will kill us, anyway.

It's time we look at the consequences of what we do and how we live, the advertising we heed, the investments we make, our leisure time activity, how we respond to our patients, our employees, our families and the strangers we pass.

It's time we discard our prejudices. It's time we acknowledge and talk about the threat we know is there. It's time we feel our oneness with the "grass roots" and go where the life spirit leads if we don't want this planet to self destruct.

Margaret R. Dietze, MD
Dearborn

Doctor Gerald Drake's article discusses the horrors of nuclear war. He says the only answer is prevention. *So what's new?* Everybody understands nuclear war is horrible and nobody wants a nuclear war. However, if people believe that you can negotiate the abolition of nuclear arms, you are sadly mistaken.

If other people believe that unilateral disarmament is the answer, they are not only sadly misinformed, but also extremely naive.

I wish we could negotiate nuclear arms reduction, but it simply is not possible. Treaties only appear to be the easy answer, they will do nothing but strengthen the Russian position. During Detente, the Russians continued to gain the superior position. They did not lose their insecurity, they only became more aggressive.

Establishing greater economic ties with the Russians has only resulted in a more hostile posture. You can only deal with these people through quiet strength. People of an aggressive and hostile personality only understand strength. How long will it take Americans to understand?

Joseph Arends, MD
Troy

Medical schools grateful

The following letters have been received by MSMS in response to recent grants to the state's medical schools.

Please convey our sincere appreciation to the Michigan Foundation for Medical and Health Education for the fine gifts toward loan funds for students in the amount of $3,861.00, and to the James D. Bruce Fellowship Fund in the amount of $11,650.00. This is most welcome support and will aid us immeasurably in our work.

John R. Mecouch
Director, Medical Campus
Financial Development Office
The University of Michigan

This letter will acknowledge the Foundation's check in the amount of $150 representing the contribution for 1983 from the James D. Bruce Fellowship Fund for graduate medical education.

The contributions to Saginaw General Hospital, St. Mary's Hospital and Saginaw Cooperative Hospital have been handled as in the past.

Please convey to the proper parties the deep appreciation of our three hospitals.

Thos. J. Hetherman
Secretary-Treasurer
Saginaw Central Hospital
Council
Michigan State University
College of Human Medicine programs

Thank you very much for your recent letter and for your generous contribution of $4,257. It will be deposited into the student loan account which was established upon receipt of your donation last year. These funds are used for emergency student loans, augmenting the resources available to the medical school for such purposes.

You are no doubt aware that federal cash contributions have been eliminated almost entirely, and so the support of foundations like yours is especially welcome and appreciated.

Thank you again for your continuing concern for our medical students and medical education.

Henry L. Nadler, MD, Dean
Wayne State University
School of Medicine

Thanks to auxiliary

The following letter arrived recently at MSMS headquarters.

On behalf of the Board of Trustees of the Organ Procurement Agency of Michigan, I wish to express our sincere appreciation for the efforts of the Michigan State Medical Society Auxiliary in enhancing organ donor awareness.

The pamphlet created by your organization is not only attractive, but also informative. Your initiation of an Annual Organ Donor Awareness Week proclamation by the Governor is commendable. We are very proud to participate in this endeavor.

Again, thank you for your help and support of organ donation.

Michael P. Kaplan, MD
President, Organ
Procurement Agency
of Michigan

By James L. Fenton, MD

The new Michigan Board of Medicine

The Michigan Board of Medicine can look forward to a busy but challenging year in 1984. In addition to processing license renewals for one-third of the 21,000 physicians licensed in Michigan, giving two FLEX examinations for new physicians, and handling many disciplinary matters, there also will be CME audits, foreign medical school evaluations, implementation of the FLEX 1-FLEX 2 system, and determining continued competence criteria for all licensees.

We begin this year with both new staff and new board members. Carl Cross, RPH, licensing executive for the Board of Medicine since 1980, resigned in November to begin study for the Lutheran ministry. Carl was a dedicated and extremely capable leader who will certainly be missed by both staff and board members. However, his shoes are to be ably filled by Herman Fishman, an experienced licensing executive in the Department of Licensing and Regulation who will continue in the footsteps of Carl Cross and Bert Brennan.

Half new

Due to resignations, normal completion of tenure, and appointments to the board by the new administration, more than half of the Board of Medicine members are new in 1984. Although we are losing eight experienced hands, there are excellent replacements joining us to carry on the many board functions. Following this article there are brief introductions of our new board members, Larry J. Andreini, MD; Norman Bolton, MD; Emma Jane Conklin, MD; George Tsiatalas, MD, and Richard Wakulat, MD. These five new members will join me on the Board along with five additional current members, Henry Kallet, MD; John Fennessey, MD; Addison Prince, MD; Charles Vincent, MD, and Karen Kotch, PA. Ms. Kotch was recently reappointed to a second four year term.

The lay members are Lee Gonzales, Betty Ann Korzenny and Thomas White.

I would like to personally thank the former board members for their time and efforts on behalf of the citizens of Michigan. Carol Pearson, MD; James Breneman, MD; Donald Kuiper, MD; Robert Gibson, MD, and Edward Weddon, MD, gave many years of dedicated service to the Board of Medicine. My special thanks to former chairperson Donald Kuiper and former vice-chairperson James Breneman for all their extra board work and for the help which they have given me in preparing to be the new chairperson of the Board of Medicine.

Only the family members of these five hard-working volunteers know the many, many hours

Continued on page 116

Doctor Fenton

James L. Fenton, MD, FACR, Bay City radiologist, was recently elected President of the Michigan Board of Medicine for 1984. The membership of the Board of Medicine is composed of 10 MDs and four laypersons who regulate and license the 20,000 MDs in the state. Doctor Fenton has been a member of the Board of Medicine since 1977 and is in his second four year term. He is a former three term Bay City commissioner, a former member of Bay City Community Concert Board, and is a long time member of the Bay City Concert Band.

Doctor Fenton is board certified in radiology and nuclear medicine. He is a fellow of the American College of Radiology and is a counselor representing Michigan in the American College of Radiology. He is a member of the executive committee of the Michigan Radiological Society, and past president of the Saginaw Valley Society.

Doctor Fenton is past president of the Bay-Arenac-Iosco Counties Medical Society, former chief of staff of Samaritan Hospital, and is a member of the board of directors of the Bay Area United Way. Doctor Fenton is an honor graduate in mechanical engineering from the University of Michigan, and received his medical degree cum laude from the Wayne State University School of Medicine. He is a member of the Radiological Society of North America and the American Roentgen Ray Society. He is a staff radiologist at Bay Medical Center, Gladwin Area Hospital and Tolfree Memorial Hospital, West Branch.

They serve on the Board:

Andreini

Bolton

Larry J. Andreini, MD
Wells

Doctor Andreini is a new Board member. A family physician, he is assistant clinical professor with Michigan State University College of Human Medicine. He is a graduate Creighton University School of Medicine, and an MSMS member.

Norman Bolton, MD
Birmingham

Doctor Bolton, also a new Board member, is a board-certified surgeon. He is a former MSMS delegate, and past chairman of the Wayne County Claims Review Committee. He is a member of the teaching staff at Sinai Hospital of Detroit, and a graduate of the University of Michigan Medical School.

Conklin

Fennessey

Emma Jane Conklin, MD
Plymouth

Doctor Conklin, a new Board member, is executive administrator of Wayne County General Hospital. An internist and MSMS member, she is a graduate of the University of Michigan Medical School.

John Fennessey, MD, JD
Detroit

Doctor Fennessey has been a Board member since 1978. He is editor, Detroit Medical News, and associate pathologist, Samaritan Health Center, Detroit. Doctor Fennessey is an MSMS delegate and member of the State Bar. He serves on the Wayne County Medical Society Council.

Gonzales

Kallet

Lee Gonzales
Flint

Mr. Gonzales is staff assistant to US Rep. Dale Kildee. He is a new member of the Board. He holds a masters of public administration from the University of Michigan-Flint, and is former assistant director of the Spanish Speaking Information Center of Flint. He is a member of several Hispanic, Boy Scout and Democratic Party organizations.

Henry A. Kallet, MD
Ann Arbor

Doctor Kallet has served on the Board since 1977. Board certified in pathology and nuclear medicine, he is director of laboratories, Chelsea Medical Laboratories and Hillsdale Community Health Center. He is a delegate to MSMS and the College of American Pathologists. He serves on the MSMS Medicaid Liaison Committee.

Korzenny

Kotch

Betty Ann Korzenny, PhD
Haslett

Doctor Korzenny is a principal partner of the wellness consulting firm, Quality Life Associates, and specializes in communications and adult education. She holds degrees from Vassar and Michigan State University.

Karen Kotch, PAC
West Bloomfield

Mrs. Kotch has been on the Board for five years. A certified physician assistant, she practices in the pediatrics department of Henry Ford Hospital's West Bloomfield Center. Mrs. Kotch is vice chairperson and former chairperson of the Michigan physicians assistants' licensing board, and is a member of the American Academy of Physicians Assistants. She holds degrees from the College of New Rochelle, NY, and from Mercy College, Detroit.

Prince

Tsiatalas

Addison Prince, MD
Detroit

Doctor Prince, an obstetrician-gynecologist, has served on the Board of Medicine since 1977. A graduate of Wayne State University School of Medicine, he is a member, American Colleges of obstetrics and gynecology, and surgery.

George Tsiatalas, MD
Birmingham

Doctor Tsiatalas, a new Board appointee, is a private practice surgeon on the staff of Beaumont Hospital, Royal Oak. He is a graduate of the Medical School of the National University of Athens, a member of the Michigan Society of General Surgeons and chairman of the Medical Care Appraisal and Utilization Review Committee of Madison Community Hospital, Madison Heights.

Vincent

Charles C. Vincent, MD
Detroit

Doctor Vincent has served on the Board since 1982. An obstetrician-gynecologist, he is a member of the MSMS Committee on State Legislation and Regulations. He is associate dean for admissions at Wayne State University and serves on the attorney discipline board of The State Bar.

Richard H. Wakulat, MD
Charlevoix

Doctor Wakulat, a new Board appointee, is internal medicine chairman at Burns Clinic Medical Center. He is a member of the MSMS Committee on Aging and is president of the Northern Michigan Medical Society. He is chief of medical services at Northern Michigan Hospitals and a member of the Michigan Psychotropic Drug Use Committee. (No photo)

Thomas White
Detroit

Mr. White, a new Board appointee, is administrative assistant to the president of the American Federation of State, County and Municipal Employees. He specializes in labor relations. (No photo available)

By C. William Howe
and Catherine A. Rosario

How the Board of Medicine works

The Michigan Board of Medicine is a 14-member board responsible for licensing, examining and regulating Michigan doctors of medicine. It is housed within the Department of Licensing and Regulation, and established pursuant to the Public Health Code, 1978 PA 368, as amended.

The Board includes 10 physicians, one physician's assistant, three public members who are appointed by the governor to four-year terms, and the Department Director who is an ex officio member. The Board of Medicine's support staff is located in the department's Bureau of Health Services.

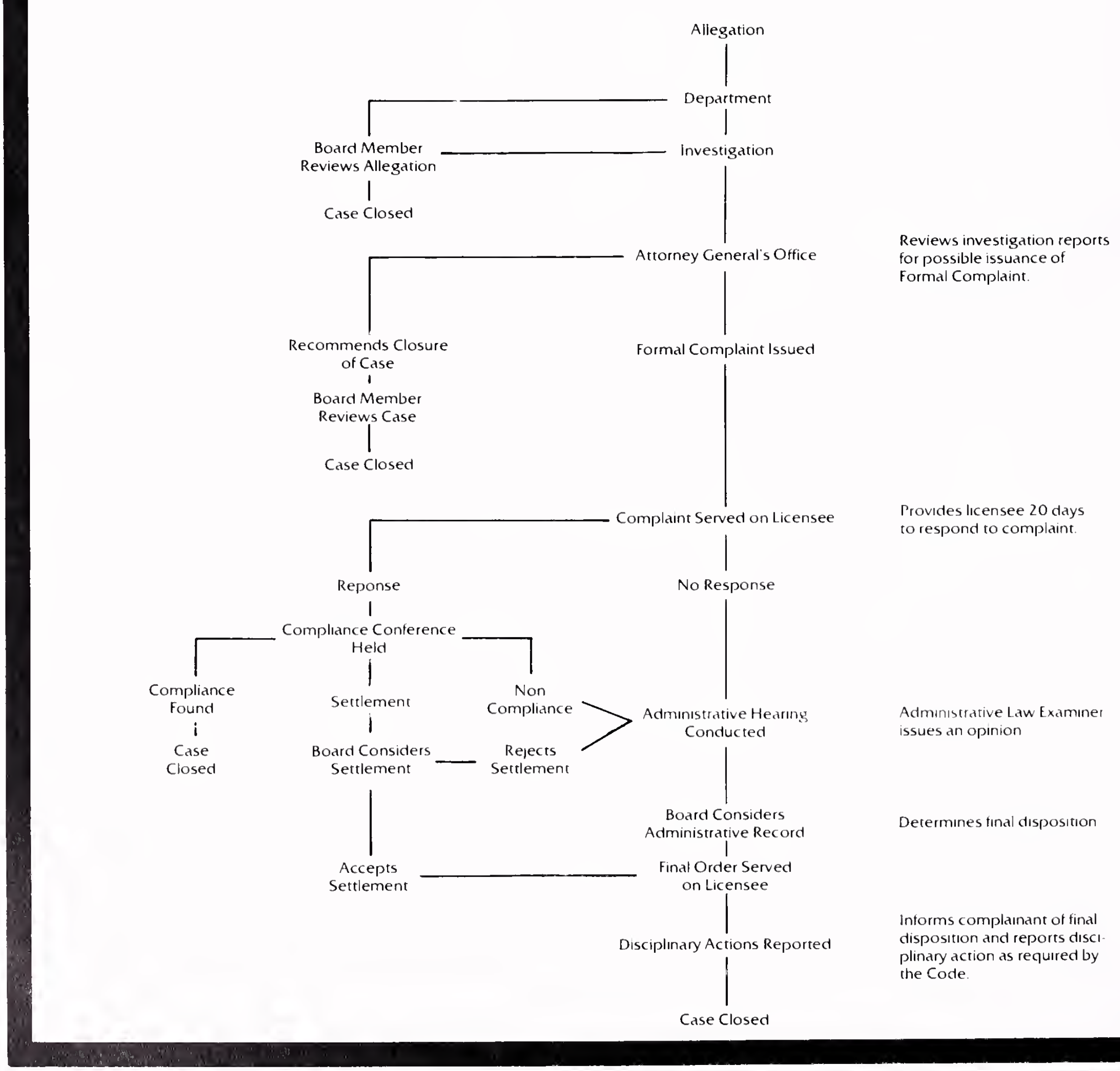
The Board's authority

In addition to issuing and renewing medical licenses, the Board of Medicine also is responsible for protecting the public health, safety and welfare by regulating the practice of medicine by licensed physicians. The Public Health Code provides the Board with the authority to discipline licensees, establishes the acts or omissions constituting violations of the Code, and sets

---

Mr. Howe is director, Bureau of Health Services, Department of Licensing and Regulation. Ms. Rosario is a departmental analyst for the bureau.

Department of Licensing and Regulation
Bureau of Health Services
Complaint Flow Chart


Allegation
Department
Board Member Reviews Allegation
Investigation
Case Closed
Attorney General's Office
Recommends Closure of Case
Formal Complaint Issued
Board Member Reviews Case
Case Closed
Complaint Served on Licensee
Reponse
No Response
Compliance Conference Held
Compliance Found
Settlement
Non Compliance
Administrative Hearing Conducted
Case Closed
Board Considers Settlement
Rejects Settlement
Board Considers Administrative Record
Accepts Settlement
Final Order Served on Licensee
Disciplinary Actions Reported
Case Closed

Reviews investigation reports for possible issuance of Formal Complaint.

Provides licensee 20 days to respond to complaint.

Administrative Law Examiner issues an opinion

Determines final disposition

Informs complainant of final disposition and reports disciplinary action as required by the Code.

forth the penalties the Board may impose for said violations.

Sources of complaints

How does the Board become aware of a physician's alleged violation? Sources include notification of the revocation, suspension or limitation of hospital staff privileges; judgments, awards and settlements in malpractice suits; and written notice of felony convictions from state courts. The Code requires the insurance commissioner, licensed hospitals, and other entities to report these actions to the Board.

In addition, the general public, other health professionals, or anyone who believes a violation may have occurred may submit accusations. Further, during the course of routine pharmacy inspections or investigations of licensees other than medical physicians, medical licenses may be implicated and an inquiry triggered into the practice of the physicians involved.

Local and federal law enforcement agencies, including the Drug Enforcement Administration, inform the Board of arrests, investigations and results. And finally, all other states in which a physician is licensed notify the Board of any disciplinary action they take.

According to the Public Health Code, a member of the Board of Medicine and department personnel review allegations to determine if there is a reasonable basis to believe a violation of the Public Health Code has occurred. If they find a basis the Department of Licensing and Regulation authorizes and conducts an investigation.

At the conclusion of the investigation, the department forwards the case file to the Department of Attorney General, Health Professionals Division, for review and possible issuance of a complaint alleging a violation of the Public Health Code.

The Complaint, Notice of Opportunity to Show Compliance and Informational Statement are subsequently served on the accused physician, who is allowed 20 days to file a response. The physician's failure to respond to the complaint or denial of the charges in the complaint result in the scheduling of an administrative hearing.

The physician named in the complaint may request a compliance conference, which allows him or her to show compliance with all lawful requirements to retain his/her license to practice medicine.

The compliance conference may result in the physician being found to be in compliance with the Public Health Code, in which case the case is closed; the physician being found in noncompliance with the Public Health Code, in which case an administrative hearing is scheduled; or a proposed settlement being drafted, in which case the proposal is presented to the Board for acceptance or rejection.

A rejection of the proposal by the Board of Medicine will typically cause the matter to be scheduled for an administrative hearing.

The Department of Licensing and Regulation conducts administrative hearings. At their conclusions, the hearing examiners prepare recommended findings of fact and conclusions of law which may be accepted or rejected by the Board of Medicine. Acceptance of the recommended findings of fact and conclusions of law and a review of the administrative record are the basis for Board of Medicine decisions in contested cases.

If the Board concludes that the evidence presented in the contested case has established a violation of the Public Health Code, it issues and serves a final order setting forth the sanction, which may include a reprimand, fine, probation, license limitation, license suspension, or license revocation.

In situations where it is determined that a licensed physician is an imminent threat to the public health, safety and welfare, the process is modified. The Board of Medicine has the authority to issue an order of summary suspension which immediately suspends the physician's license, pending the outcome of an administrative hearing.

Disciplinary decisions automatically are reported to insurance companies, professional associations and societies, state and federal law enforcement agencies, administrators of Medicaid and Medicare programs, sister state regulatory boards, and other interested organizations and individuals upon request.

The Michigan Administrative Procedures Act of 1969 provides for judicial review of final decisions of the Board, although the courts may delay implementation of the Board's disciplinary order while the appeal progresses through the court system.

Regaining licensure

Licenses suspended for longer than six months are not reinstated automatically. At the end of the suspension, or not sooner than one year after a revocation, a physician may petition the Board for reinstatement of the license. After a hearing, and if the Board is satisfied that the physician is of good moral character, is able to practice with reasonable skill and safety to patients, and should be permitted in the public interest to resume practice, it may grant reinstatement of full licensure. The Board also may issue a limited license restricting the licensee's practice to a specific field or physical location, or prohibiting the prescribing or possessing of controlled substances.

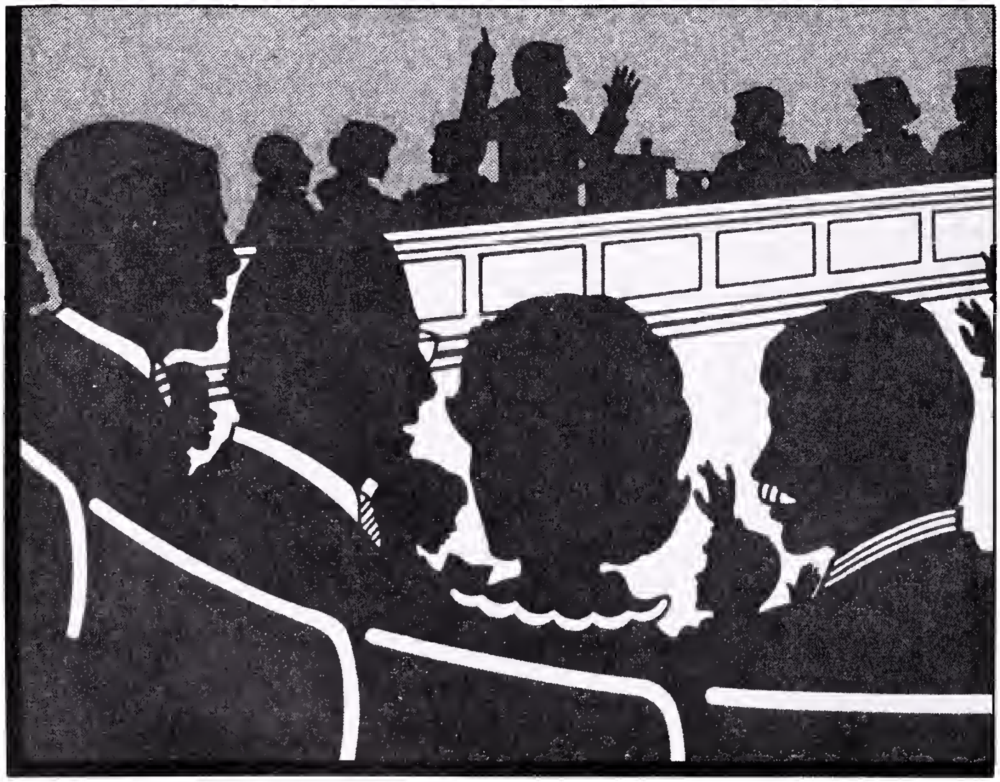
The Board may require a physical and/or mental examination prior to reinstatement to assure competence to resume practice. Reinstatement may be conditioned upon certain terms of probation, including supervision of the licensee's practice and periodic reporting to the Board by the physician and supervisor, as well as additional continuing medical education requirements.

The complaint process and functions currently are being evaluated by a Special Study Committee selected by the Health Occupations Council at the request of Department Director Elizabeth P. Howe.

each one spent in Lansing on board business only to be asked not to take their per diem since the state has so little money. These former board member physicians now will be asked to serve again as expert witnesses and case reviewers. Thank you one and all.

New exams

A major goal of the Board of Medicine in 1984 will be setting up the new examination system and phasing out the old National Board and FLEX exams. Doctor Kuiper, past Board Chairman, has been appointed Region V coordinator by the Federation of State Medical Boards, and will assist the Michigan Board as well as the other Midwestern State Medical Boards with the implementation of the FLEX 1 — FLEX 2 system. The first FLEX 1 examination will probably be given in 1985 followed by FLEX 2 sometime later. The last National Board Examination and the last old FLEX examination probably will be given in 1986.



The Public Health Code of 1978 mandates the determination of continued competence of licensees by the Health Boards. The deadline for implementation of the code is October 1, so the Board of Medicine will make this a top priority item during the next few months. Several committees have been working on the problem of continued competency for the past four years, including those of the board and joint committees with both Licensing and Regulation, and the Michigan State Medical Society. Although many options have been considered, no final decisions have been made. Among the plans proposed are CME, written examinations, peer review, specialty board recertification, and various combinations of CME and peer review. No one plan is in the forefront at this writing.

The evaluation of foreign medical graduates and foreign medical schools continues to be a problem for State Boards of Medicine. The recent influx of graduates from Caribbean medical schools further complicates an already difficult situation. The Federation of State Medical Boards is attempting to evaluate medical schools but is having only limited success. The Missouri Board of Medicine is proposing an alternate plan for our consideration which would grant approval of foreign medical schools in a somewhat different manner. In spite of intense efforts by many boards no unanimity of opinion exists about the foreign medical school and foreign medical graduate situation. We hope, however, that the FLEX 1 — FLEX 2 system will partially solve this problem.

Immunity problem

The Board of Medicine has been the object of litigation in the past, but recently board members also have been named in a suit as individuals. In order to protect staff and Board Members in the future, legislation has recently been introduced which would grant immunity and indemnify individuals acting in their official capacity as members of the Board. If this legislation is not successful, I believe fewer people will be willing to serve on the Board of Medicine, fearing substantial financial liability for official acts of the Board, many of which are beyond their control. I hope 1984 will see a solution to this complex matter.

As I begin a very busy year as your new Board of Medicine Chairperson, may I take this opportunity to invite you to attend one of our meetings. The Michigan Board of Medicine meets in open session in the Conference Center at 811 Ottawa Street, Lansing, the second Wednesday of the month at 9:30 AM.

We hope to resume our monthly meetings this year, after having been limited to six meetings annually in recent years due to budgetary constraints. You are cordially invited to attend any of our meetings, but I suggest you call the Board Office at 517-373-0680 to confirm the meeting you plan to attend.

By Frederick W. Minkow, MD

MSMS, L & R and Board work to improve process

MSMS and the Michigan Department of Licensing and Regulation together are tackling some tough issues regarding the Michigan Board of Medicine's ability to manage disciplinary actions against Michigan physicians.

These issues have come to light through MSMS concerns and media attention to specific cases' progress through Board of Medicine processes.

The results of the cooperative work to date are reports by both MSMS and a special committee of the Health Occupations Council (HOC), chaired by Thomas J. DeKornfeld, MD, Ann Arbor. Both reports summarize studies of the Board of Medicine disciplinary process, one study carried out by MSMS and the other by the HOC committee at the direction of the Department of Licensing and Regulation Director Elizabeth P. Howe.

MSMS and the HOC committee have met to discuss their respective findings and the committee has issued a preliminary report to Mrs. Howe. The MSMS Committee on State Legislation and Regulations now is reviewing the report and will continue to work with the department to improve the disciplinary process.

The HOC committee's report contains several recommendations for action which MSMS supports.

The report does call for the following changes, which MSMS approves:

1) That Board of Medicine members would enjoy immunity from lawsuits brought as a result of their official board actions.

2) That legislation should be developed to make it less easy for the courts to forestall Board actions through the injunction process.

3) That the Department of Licensing and Regulation's Bureau of Health Services (under which the Board of Medicine works) should be reorganized to provide better communication between groups working on disciplinary actions and to keep better track of each case.

4) That appropriations to carry out the Board's mission better reflect the contributions made to state coffers by the physicians licensed by the Board.

The Health Occupations Council's committee report did not address the hearing process, where MSMS feels much must be done to uphold Board actions and to bring them swiftly to bear on the disciplined persons, who now may stall them off through lengthy legal maneuvers.

With the excellent cooperation and spirit of teamwork shown by Mrs. Howe and her department to date, we are certain that we will continue to see further steps toward improving the Michigan Board of Medicine's efficiency.

Doctor Minkow, of Ann Arbor, is chairman of the MSMS Committee on State Legislation and Regulations.

A word from the L & R director

The following are comments of Elizabeth P. Howe, director, Department of Licensing and Regulation, on some of the major issues faced by the Michigan Board of Medicine. Mrs. Howe's comments are taken from her address to the 1983 Congress of the Michigan Association of the Professions.

The issue of governmental immunity has received much notice since Attorney General Kelley announced an initiative toward the legislative leadership and the State Bar late in June.

The focus has been on whether a citizen should be able to sue government and while clearly important, it did not encompass the needs of our Board of Medicine members, who have been subjected to a suit for damages in excess of $7 million by a physician who was denied licensure.

At present, individual state employees and those who serve the state in appointive capacities can be and are the subjects of liability actions. This includes those who serve as members of Licensing and Regulation's boards and task forces.

For that reason, after hearing the concerns of individual board members and the various professional associations, we were grateful that Representative Jim O'Neill offered to sponsor HB 4782.

Immunity

Under current law, a state officer or employee can be held personally liable for actions taken within his or her official duties — even though the state agency cannot be sued because of its governmental immunity. HB

Continued on page 119

Digest of Proceedings, Michigan Board of Medicine

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are summarized below by MSMS legal counsel from official memoranda to MSMS. Any subsequent actions of the board will be printed in future issues.

Doctor Involved: Rosemarie Blosen, MD
Complaint: Administered sodium pentothal notwithstanding the patient's refusal to grant consent to same, having previously had a bad experience with sodium pentothal.
Facts:
Decision: Consent Order, July 20, 1983: Reprimand; Respondent henceforth required to document informed consent prior to anesthesiology services.
Dated: January 30, 1984

Doctor Involved: Alfred L. Chatman, MD
Complaint: Prescribing Ludiomil and Dexedrine on many occasions for a non-patient.
Decision: Consent Order, October 1983: probation for one year, during which Respondent can be requested to disclose records documenting the care of that particular person.
Dated: January 31, 1984

Doctor Involved: Bruce E. Fishman, MD
Complaint: Respondent pled guilty in Federal Court re distribution of controlled substances, a felony.
Facts: In Federal Court, charged with distributing Dilaudid, Preludin, Percodan, Demoral, Desoxyn for non-medical purposes, in concert with others.
Decision: Summary suspension of license on August 10, 1983
Status: Hearing designated for September 6, 1983 to determine what further action, if any, should be taken. Result of hearing not yet known.
Dated: January 30, 1984

Doctor Involved: James E. Gotham, MD
Complaint: Distribution of Quaaludes in violation of 21 USC 841
Facts: Respondent pled guilty in Federal Court to distribution of Quaaludes which is a felony. Court placed him on probation, conditioned upon seeking couseling for alcoholism and psychiatric counseling.
Decision: Summary suspension of license, August 10, 1983
Status: Notice of hearing for September 6, 1983, to determine what further action, if any, should be taken.
Comments: Disposition at September 6, 1983 not yet known.
Dated: January 30, 1984

Doctor Involved: Bruce R. Krygowski, MD
Complaint: Unlawful distribution of controlled substances.
Facts: Respondent pled guilty in Federal Court to unlawful distribution of Talwin. In Federal Court, Respondent was sentenced to a year and a day but put on probation for three years and ordered to pay a fine of $10,000 within three years. If paid within two years, probation would terminate at end of second year.
Decision: Order of summary suspension, December, 1983: License summarily suspended at that time.
Dated: January 31, 1984

Doctor Involved: Robert J. July, MD
Complaint: Prescribed Percodan and Valium at various times to a patient with a known history of substance abuse.
Decision: Order, December, 1983: license summarily suspended.
Dated: January 31, 1984

Doctor Involved: Arnold Podolsky, MD
Complaint: Misuse of Demerol
Facts: On a single date improperly obtained hospital Demerol, allegedly for personal use. Respondent not presently engaged in active practice.
Decision: Consent Order — probation for two years; psychiatric therapy and random laboratory testing; license limited for one year to prohibit obtaining and dispensing controlled substances for one year.
Comments: Respondent wishes to pursue further education before returning to regular practice.
Dated: January 30, 1984

Doctor Involved: Timothy Rudolph, Jr., MD
Complaint: Distribution of Desoxyn
Facts: Respondent pled guilty to such charge in Federal Court.
Decision: Summary suspension, October 12, 1983, by Board.
Status: Notice given to Respondent for formal hearing to be held on November 22, 1983. Outcome not presently known to MSMS.
Dated: January 31, 1984

Doctor Involved: Robert Sosa, MD
Complaint: Prescribed Desoxyn to a patient, inappropriately, over a period of several months.
Decision: Consent Order, August 10, 1983: Limited license; Respondent not to possess controlled substances unless same is prescribed by a physician for Respondent's own use; limited license is for 181 days, after which Respondent may ask reclassification.
Dated: January 30, 1984

4782 would provide state officers and employees with the same protection as their employers for activities in furtherance of governmental responsibilities.

HB 4782 would require that a cause of action, based upon allegations that a state officer or state employee has wrongfully performed or failed to perform any activity in the course of his or her governmental responsibility, be brought against the responsible state office or agency, in its name, rather than against the state officer or employee.

This legislation is intended to work in tandem with the purchase of liability insurance to indemnify governmental agencies, which requires State Administrative Board approval.

Funding

Then there is the issue of funding for programs.

On August 5 Attorney General Kelley, in a formal opinion, told us that if a law is on the books, we have to run the program, regardless of whether or not the funding was cut by an Executive Order or simply not appropriated. In other words, we can and must rob Peter to pay Paul to get the job done.

While the opinion will cause short-term hardship across-the board, I can see a long-range beneficial effect. Fiscal implications of ideas and pet projects will become logical extensions of the legislative committee process. It can encourage the Legislature and our budget planners to identify programs we can't afford and get them out of the law books. Both the state's laws and its programs could be far more streamlined than in the past — and when cutbacks are required, the changes can truly be by program instead of by laying off a person or two here or there. The opinion in effect suggests a sunset-type review of every agency — beginning with the laws not being implemented.

If the program is important, however, from now on there will have to be a way to pay for it tied right to the enabling legislation. State Representative Richard Fitzpatrick led the way in this regard just a few months ago. Fitzpatrick worked with the realtor's association to develop legislation requiring continuing education for all brokers and salespeople. And because he agreed when we explained our funding need, the law signed by the Governor not only imposes the requirement, but raises license fees to pay for the monitoring of that program and no other. We are to keep the added $3 per license to run the program.

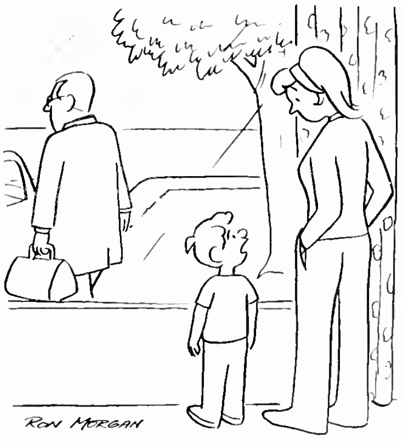
Parity

It is my belief that general fund/general purpose funding for the Department of Licensing and Regulation should approach parity with the revenue produced by the fees which are collected from licensees and that special innovations — and initiatives which result from the legislative process — should have earmarked (restricted) funding until they can be folded into the overall budget planning process.

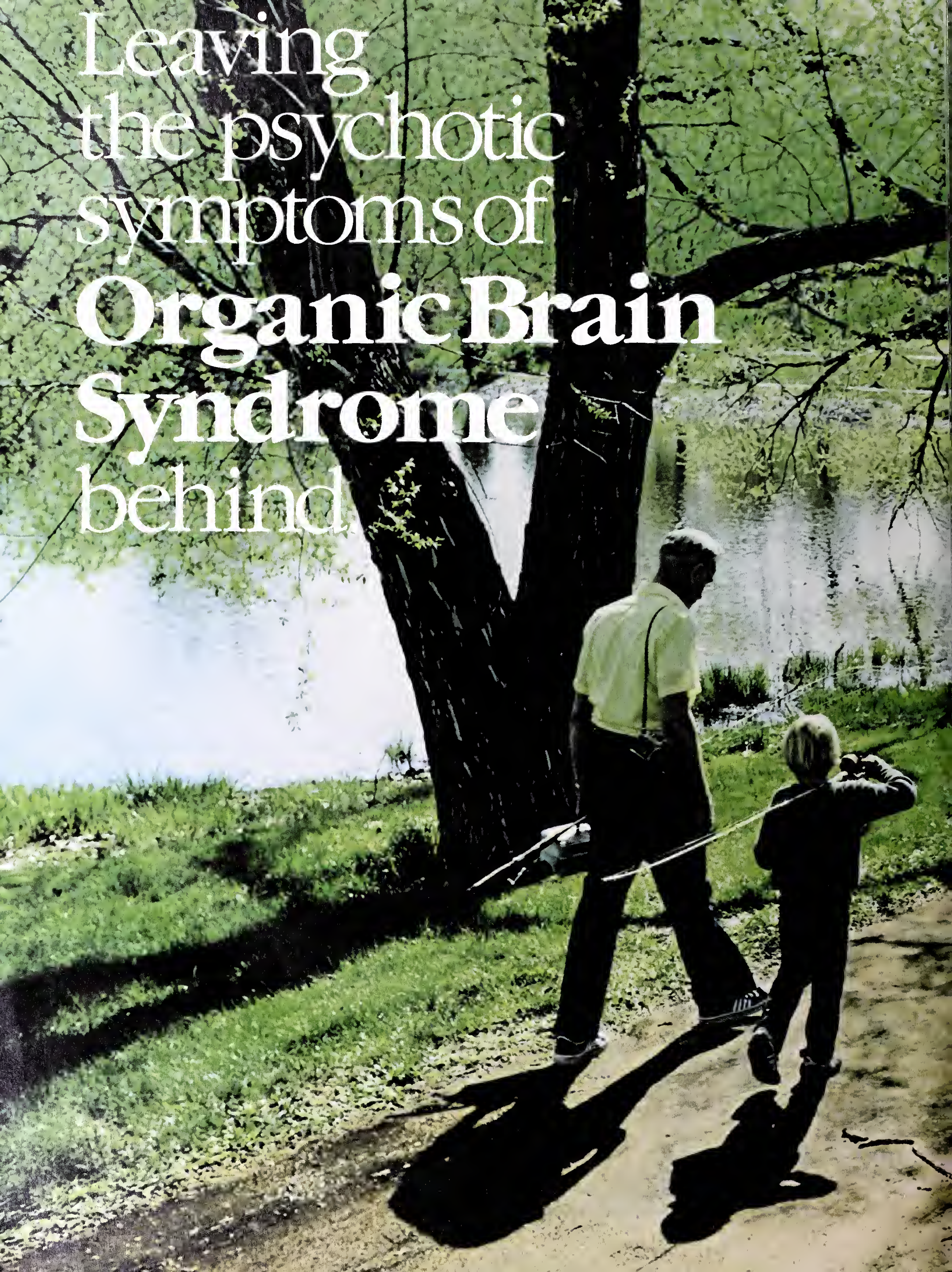
Some professions will always raise more money than they can spend in a given period, others will always raise less. There is a need for consumer protection in general so overpowering that minor variations between professional needs in any given year must be understood and accommodated. In the long run, we are all consumers and will pay for the protection.

The only negative that I have encountered in test marketing this concept to small groups of professionals, is that some of you then take the jump back to the good old days and see profession-by-profession licensing revenue dedication. That day has of course been written off by the intervening reform legislation, but I discourage such practices for an additional reason: it will simply be a different form of cannibalism and once again, the consumer will be forgotten.

I submit that until the day arrives when you and I place the consumer in number one position, we will never be able to be successful in securing your positions as licensed professionals nor the department's position as an instrument of public policy. And others will set your agenda.



"When is Dad going to quit practicing medicine and really do it?"


Leaving
the psychotic
symptoms of
Organic Brain
Syndrome
behind.

Effective

Treatment with Navane can produce improvement in psychotic symptoms such as hallucinatory behavior and unusual thought content as well as hostility, disorientation and depressive mood,[1,2] leaving the elderly patient more alert[2] and better able to participate in the activities of family life.

Well tolerated

Navane is generally well tolerated by elderly patients. Excessive sedation or drowsiness has been reported, but is uncommon.[1] Anticholinergic effects[3] and hypotension[4,5] are reported, but rarely. Should they occur, extrapyramidal symptoms can usually be readily controlled.

Navane®

(thiothixene) (thiothixene HCl)

Capsules 1 mg, 2 mg, 5 mg, 10 mg, 20 mg
Concentrate 5 mg/ml Intramuscular 2 mg/ml, 5 mg/ml

See following page for a brief summary of prescribing information.

ROERIG *Pfizer*
A division of Pfizer Pharmaceuticals
at the forefront of psychopharmacology

© 1982, Pfizer Inc.

Navane®

(thiothixene) (thiothixene HCl)

References 1. Util TM, Unverdi C, Wohlrade J, et al: Drug therapy of psychosis associated with organic brain syndrome. Presented as a Scientific Exhibit at the American Public Health Association Centennial, Atlantic City, New Jersey, November 12-16, 1972. 2. Katz MM, Util TM: Video methodology for research in psychopathology and psychopharmacology. *Arch Gen Psychiatry* 31:204-210, 1974 3. Ketai R: Psychotropic drugs in the management of psychiatric emergencies. *Postgraduate Medicine* 58:87-93, 1975. 4 Birkett DP, Hirschfield W, Simpson GM: Thiothixene in the treatment of diseases of the senium. *Curr Ther Res* 14 775-779, 1972 5. Data on file at Roerig.

Capsules available in 5 strengths

1 mg

2 mg

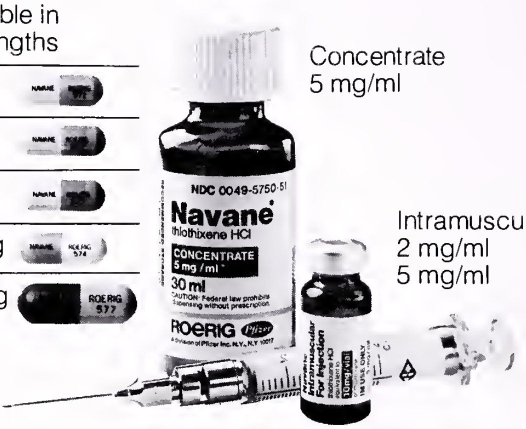
5 mg

10 mg

20 mg

Concentrate 5 mg/ml

Intramuscular 2 mg/ml 5 mg/ml



BRIEF SUMMARY OF PRESCRIBING INFORMATION
Navane® (thiothixene) Capsules: 1 mg, 2 mg, 5 mg, 10 mg, 20 mg
(thiothixene hydrochloride) Concentrate: 5 mg/ml, Intramuscular: 2 mg/ml, 5 mg/ml

Contraindications: Navane (thiothixene) is contraindicated in patients with circulatory collapse, comatose states, central nervous system depression due to any cause, and blood dyscrasias. Navane is contraindicated in individuals who have shown hypersensitivity to the drug It is not known whether there is a cross-sensitivity between the thioxanthenes and the phenothiazine derivatives, but the possibility should be considered

Warnings: *Usage in Pregnancy* – Safe use of Navane during pregnancy has not been established Therefore, this drug should be given to pregnant patients only when, in the judgment of the physician, the expected benefits from the treatment exceed the possible risks to mother and fetus Animal reproduction studies and clinical experience to date have not demonstrated any teratogenic effects

In the animal reproduction studies with Navane, there was some decrease in conception rate and litter size, and an increase in resorption rate in rats and rabbits, changes which have been similarly reported with other psychotropic agents. After repeated oral administration of Navane to rats (5 to 15 mg/kg/day), rabbits (3 to 50 mg/kg/day), and monkeys (1 to 3 mg/kg/day) before and during gestation, no teratogenic effects were seen. (See Precautions.)

Usage in Children – The use of Navane in children under 12 years of age is not recommended because safety and efficacy in the pediatric age group have not been established.

As is true with many CNS drugs, Navane may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery, especially during the first few days of therapy Therefore, the patient should be cautioned accordingly.

As in the case of other CNS-acting drugs, patients receiving Navane should be cautioned about the possible additive effects (which may include hypotension) with CNS depressants and with alcohol

Precautions: An antiemetic effect was observed in animal studies with Navane, since this effect may also occur in man, it is possible that Navane may mask signs of overdosage of toxic drugs and may obscure conditions such as intestinal obstruction and brain tumor.

In consideration of the known capability of Navane and certain other psychotropic drugs to precipitate convulsions, extreme caution should be used in patients with a history of convulsive disorders or those in a state of alcohol withdrawal since it may lower the convulsive threshold Although Navane potentiates the actions of the barbiturates, the dosage of the anticonvulsant therapy should not be reduced when Navane is administered concurrently

Caution as well as careful adjustment of the dosage is indicated when Navane is used in conjunction with other CNS depressants other than anticonvulsant drugs

Though exhibiting rather weak anticholinergic properties, Navane should be used with caution in patients who are known or suspected to have glaucoma, or who might be exposed to extreme heat, or who are receiving atropine or related drugs.

Use with caution in patients with cardiovascular disease

Also, careful observation should be made for pigmentary retinopathy, and lenticular pigmentation (fine lenticular pigmentation has been noted in a small number of patients treated with Navane for prolonged periods). Blood dyscrasias (agranulocytosis, pancytopenia, thrombocytopenic purpura), and liver damage (jaundice, biliary stasis) have been reported with related drugs.

Undue exposure to sunlight should be avoided Photosensitive reactions have been reported in patients on Navane

Neuroleptic drugs elevate prolactin levels; the elevation persists during chronic administration. Tissue culture experiments indicate that approximately one-third of human breast cancers are prolactin dependent *in vitro*, a factor of potential importance if the prescription of these drugs is contemplated in a patient with a previously detected breast cancer. Although disturbances such as galactorrhea, amenorrhea, gynecomastia, and impotence have been reported, the clinical significance of elevated serum prolactin levels is unknown for most patients. An increase in mammary neoplasms has been found in rodents after chronic administration of neuroleptic drugs. Neither clinical studies nor epidemiologic studies conducted to date, however, have shown an association between chronic administration of these drugs and mammary tumorigenesis, the available evidence is considered too limited to be conclusive at this time.

Intramuscular Administration – As with all intramuscular preparations, Navane Intramuscular should be injected well within the body of a relatively large muscle The preferred sites are the upper outer quadrant of the buttock (i e. gluteus maximus) and the mid-lateral thigh

The deltoid area should be used only if well developed, such as in certain adults and older children, and then only with caution to avoid radial nerve injury Intramuscular injections should not be made into the lower and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel

Adverse Reactions: *Note:* Not all of the following adverse reactions have been reported with Navane (thiothixene) However, since Navane has certain chemical and pharmacologic similarities to the phenothiazines, all of the known side effects and toxicity associated with phenothiazine therapy should be borne in mind when Navane is used

Cardiovascular effects: Tachycardia, hypotension, lightheadedness, and syncope In the event hypotension occurs, epinephrine should not be used as a pressor agent since a paradoxical further lowering of blood pressure may result Nonspecific EKG changes have been observed in some patients receiving Navane. These changes are usually reversible and frequently disappear on continued Navane therapy. The incidence of these changes is lower than that observed with some phenothiazines The clinical significance of these changes is not known.

CNS effects Drowsiness, usually mild, may occur although it usually subsides with continuation of Navane therapy The incidence of sedation appears similar to that of the piperazine group of phenothiazines, but less than that of certain aliphatic phenothiazines. Restlessness, agitation and insomnia have been noted with Navane (thiothixene). Seizures and paradoxical exacerbation of psychotic symptoms have occurred with Navane infrequently

Hyperreflexia has been reported in infants delivered from mothers having received structurally related drugs.

In addition, phenothiazine derivatives have been associated with cerebral edema and cerebrospinal fluid abnormalities

Extrapyramidal symptoms, such as pseudo-parkinsonism, akathisia, and dystonia have been reported Management of these extrapyramidal symptoms depends upon the type and severity. Rapid relief of acute symptoms may require the use of an injectable antiparkinson agent. More slowly emerging symptoms may be managed by reducing the dosage of Navane and/or administering an oral antiparkinson agent.

Persistent Tardive Dyskinesia As with all antipsychotic agents tardive dyskinesia may appear in some patients on long term therapy or may occur after drug therapy has been discontinued. The risk seems to be greater in elderly patients on high-dose therapy, especially females The symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Sometimes these may be accompanied by involuntary movements of extremities

There is no known effective treatment for tardive dyskinesia, antiparkinsonism agents usually do not alleviate the symptoms of this syndrome. It is suggested that all antipsychotic agents be discontinued if these symptoms appear

Should it be necessary to reinstitute treatment, or increase the dosage of the agent, or switch to a different antipsychotic agent, the syndrome may be masked

It has been reported that fine vermicular movements of the tongue may be an early sign of the syndrome and if the medication is stopped at that time, the syndrome may not develop.

Hepatic effects: Elevations of serum transaminase and alkaline phosphatase, usually transient, have been infrequently observed in some patients. No clinically confirmed cases of jaundice attributable to Navane (thiothixene) have been reported.

Hematologic effects: As is true with certain other psychotropic drugs, leukopenia and leukocytosis, which are usually transient, can occur occasionally with Navane. Other antipsychotic drugs have been associated with agranulocytosis, eosinophilia, hemolytic anemia, thrombocytopenia and pancytopenia.

Allergic reactions: Rash, pruritus, urticaria, photosensitivity and rare cases of anaphylaxis have been reported with Navane. Undue exposure to sunlight should be avoided Although not experienced with Navane, exfoliative dermatitis and contact dermatitis (in nursing personnel) have been reported with certain phenothiazines.

Endocrine disorders: Lactation, moderate breast enlargement and amenorrhea have occurred in a small percentage of females receiving Navane. If persistent, this may necessitate a reduction in dosage or the discontinuation of therapy. Phenothiazines have been associated with false positive pregnancy tests, gynecomastia, hypoglycemia, hyperglycemia, and glycosuria

Autonomic effects: Dry mouth, blurred vision, nasal congestion, constipation, increased sweating, increased salivation, and impotence have occurred infrequently with Navane therapy. Phenothiazines have been associated with miosis, mydriasis, and adynamic ileus.

Other adverse reactions. Hyperpyrexia, anorexia, nausea, vomiting, diarrhea, increase in appetite and weight, weakness or fatigue, polydipsia and peripheral edema

Although not reported with Navane, evidence indicates there is a relationship between phenothiazine therapy and the occurrence of a systemic lupus erythematosus-like syndrome.

NOTE: Sudden deaths have occasionally been reported in patients who have received certain phenothiazine derivatives In some cases the cause of death was apparently cardiac arrest or asphyxia due to failure of the cough reflex In others, the cause could not be determined nor could it be established that death was due to phenothiazine administration.

Dosage and Administration: Dosage of Navane should be individually adjusted depending on the chronicity and severity of the condition. In general, small doses should be used initially and gradually increased to the optimal effective level, based on patient response.

Some patients have been successfully maintained on once-a-day Navane therapy.

Usage in children under 12 years of age is not recommended because safe conditions for its use have not been established

Navane Intramuscular Solution: Navane For Injection – Where more rapid control and treatment of acute behavior is desirable, the intramuscular form of Navane may be indicated It is also of benefit where the very nature of the patient's symptomatology, whether acute or chronic, renders oral administration impractical or even impossible.

For treatment of acute symptomatology or in patients unable or unwilling to take oral medication, the usual dose is 4 mg of Navane Intramuscular administered 2 to 4 times daily Dosage may be increased or decreased depending on response. Most patients are controlled on a total daily dosage of 16 to 20 mg The maximum recommended dosage is 30 mg/day. An oral form should supplant the injectable form as soon as possible. It may be necessary to adjust the dosage when changing from the intramuscular to oral dosage forms. Dosage recommendations for Navane (thiothixene) Capsules and Concentrate appear in the following paragraphs.

Navane Capsules: Navane Concentrate – In milder conditions, an initial dose of 2 mg three times daily. If indicated, a subsequent increase to 15 mg/day total daily dose is often effective.

In more severe conditions, an initial dose of 5 mg twice daily.

The usual optimal dose is 20 to 30 mg daily If indicated, an increase to 60 mg/day total daily dose is often effective. Exceeding a total daily dose of 60 mg rarely increases the beneficial response

Overdosage: Manifestations include muscular twitching, drowsiness, and dizziness. Symptoms of gross overdosage may include CNS depression, rigidity, weakness, torticollis, tremor, salivation, dysphagia, hypotension, disturbances of gait, or coma

Treatment Essentially is symptomatic and supportive For Navane oral, early gastric lavage is helpful For Navane oral and Intramuscular, keep patient under careful observation and maintain an open airway, since involvement of the extrapyramidal system may produce dysphagia and respiratory difficulty in severe overdosage. If hypotension occurs, the standard measures for managing circulatory shock should be used (I.V. fluids and/or vasoconstrictors.)

If a vasoconstrictor is needed, levarterenol and phenylephrine are the most suitable drugs. Other pressor agents, including epinephrine, are not recommended, since phenothiazine derivatives may reverse the usual pressor action of these agents and cause further lowering of the blood pressure

If CNS depression is present and specific therapy is indicated, recommended stimulants include amphetamine, dextroamphetamine, or caffeine and sodium benzoate. Stimulants that may cause convulsions (e.g picrotoxin or pentylenetetrazol) should be avoided Extrapyramidal symptoms may be treated with antiparkinson drugs

There are no data on the use of peritoneal or hemodialysis, but they are known to be of little value in phenothiazine intoxication.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals

By Gary D. Maynard, MD

MSMS recommends new medical staff section

The MSMS Medical Staff Relations Committee has been working over the past year to strengthen the ties between hospital medical staff members and their hospital administrators.

The MSMS activity is an outgrowth of a movement led by the AMA, which studied trends and concluded two years ago that medical staff members ought to be more involved in policies affecting physician/hospital relationships.

An AMA study committee had reviewed many issues affecting the health care environment prior to the AMA taking this position. Some of these issues were hospitals' expansion into ambulatory care services, medical staff representation within the hospital organization, competition, costs, contracts, corporate restructuring of hospitals, reimbursement and closed staffs.

AMA section

The study committee members agreed there was a need for the AMA to establish some system to resolve the concerns of hospital medical staffs. This thought culminated in formation of the AMA Hospital Medical Staff Section which held its first meeting on June 17, 1983.

The Michigan Delegation to the AMA and the MSMS Medical Staff Relations Committee organized hospital medical staff representatives at the meeting and held a reception/caucus meeting prior to the opening session of the new AMA Section.

Henry Domzalski, MD, Detroit, was elected secretary of the section, and Peter Dunhamel, MD, Rochester served as a reference committee chairman at both section meetings.

The MSMS Medical Staff Relations Committee then met to consider a forum for hospital medical staffs to discuss common issues and concerns, ways to increase awareness and to communicate issues affecting physicians as members of hospital medical staffs, methods to increase communications between MSMS and hospital medical staffs, and avenues to provide access to the policy-making body of MSMS.

To achieve these goals, the following approaches to hospital medical staff involvement in organized medicine were discussed: 1) The use of a new or existing council, 2) the development of an independent association that would operate like a national medical specialty society, 3) the creation of societies similar to the approach used by the American Hospital Association and the American Bar Association, and 4) the creation of a hospital medical staff section.

MSMS section

After discussing these alternatives, the MSMS Medical Staff Relations Committee asked the MSMS Board of Directors to consider a Section for Hospital Medical Staffs. They recommended that MSMS develop a hospital medical staff section and that the Medical Staff Relations Committee develop the structure and its relationship with the MSMS House of Delegates, Board of Directors and component societies and report back to the Board with recommendations. The Board approved the committee's recommendations on September 14.

With this authority, the Committee members prepared a report recommending three options regarding the medical staffs' relationship to the MSMS Board of Directors. On November 23, the board decided to enlarge the MSMS Medical Staff Relations Committee to include the officers of the proposed Hospital Medical Staff Section. This newly constituted Medical Staff Relations Committee is to meet as often as required to address the issues confronting hospital medical

---

Doctor Maynard, a Kalamazoo anesthesiologist, is chairman of the MSMS Medical Staff Relations Committee. He is vice president of medical affairs at Bronson Medical Center.

staffs and is to report to the MSMS Board.

On January 18, the MSMS Board adopted the committee's recommendations for the new section's organization. These recommendations will go to the 1984 House of Delegates. These recommendations call for the MSMS Hospital Medical Staff Section to be structured as follows:

1. A governing council shall direct the progress and activities of the Section. This council shall consist of a chairman, vice-chairman, secretary, two at-large members, plus one delegate and one alternate delegate to the House of Delegates.

2. Representatives to the Hospital Medical Staff Section shall be members of MSMS and the AMA. They shall be nominated and elected by the active voting physician members of each medical staff of JCAH accredited hospitals in Michigan. They must have clinical privileges at the institution they represent. Medical staffs should, whenever possible, elect the same representatives to this position as to the AMA Hospital Medical Staff Section.

3. The section shall be organized as an open assembly to which each hospital medical staff of JCAH-accredited hospitals in Michigan is eligible to send one elected representative.

Section operation

The following rules also are suggested as an integral part of the new section's operation: 1) The hospital medical staff representative should be someone who could acquire experience and provide continuity of representation for a period of years, 2) The hospital medical staff representative should be someone other than a current AMA delegate or alternate delegate; 3) A mechanism should be established whereby the representative of the hospital medical staff regularly communicates with the hospital medical staff and the governing body of the hospital and 4) The hospital medical staff representative should communicate on a regular basis with his/her component medical society.

The Medical Staff Relations Committee believes that issues and problems unique to hospital medical staffs will be effectively addressed through the establishment of an MSMS Hospital Medical Staff Section.

Members of the Medical Staff Relations Committee are: Robert D. Allaben, MD, Detroit; Robert W. Black, MD, Detroit; Blaine J. Dennis, student; Henry A. Domzalski, MD, Detroit; Timothy G. Howell, student; James J. Humes, MD, Detroit; Devendra Sharma, MD, Tawas City; John C. Sullivan, MD, Port Huron and William E. Madigan, MSMS Staff.

db
Systems

Diversified
Business
Systems, Inc.

INVITES YOU TO SEE A DEMONSTRATION OF

MEDPAC©

A comprehensive medical/dental insurance and patient processing computer system.

The MEDPAC System features full practice accounting functionality highlighted by management analysis and custom report generation. DB Systems provides installation, training, and full service that does not stop after system implementaton. DB Systems, and MEDPAC are backed by a staff of over 100 programmers, medical/dental consultants, and statewide support specialists. Call us today for an appoint to show you our system in your office.

(517) 349-2861

P.O. Box 26224 - Lansing, MI 48909

. . .for a healthy business

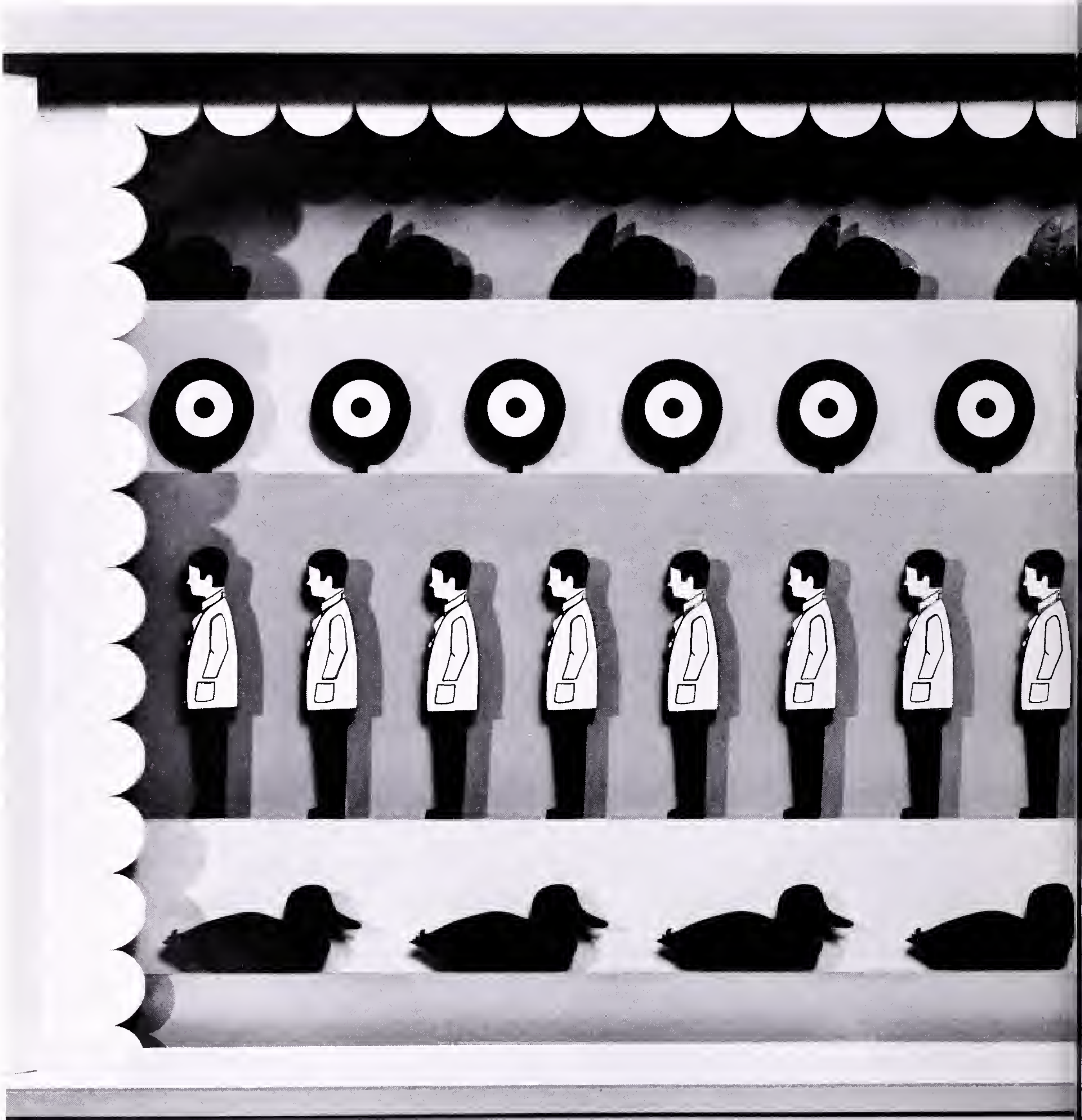
BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android®/5 mg. Buccal/10 mg. Oral/25 mg. Oral
Methyltestosterone U.S.P. Tablets

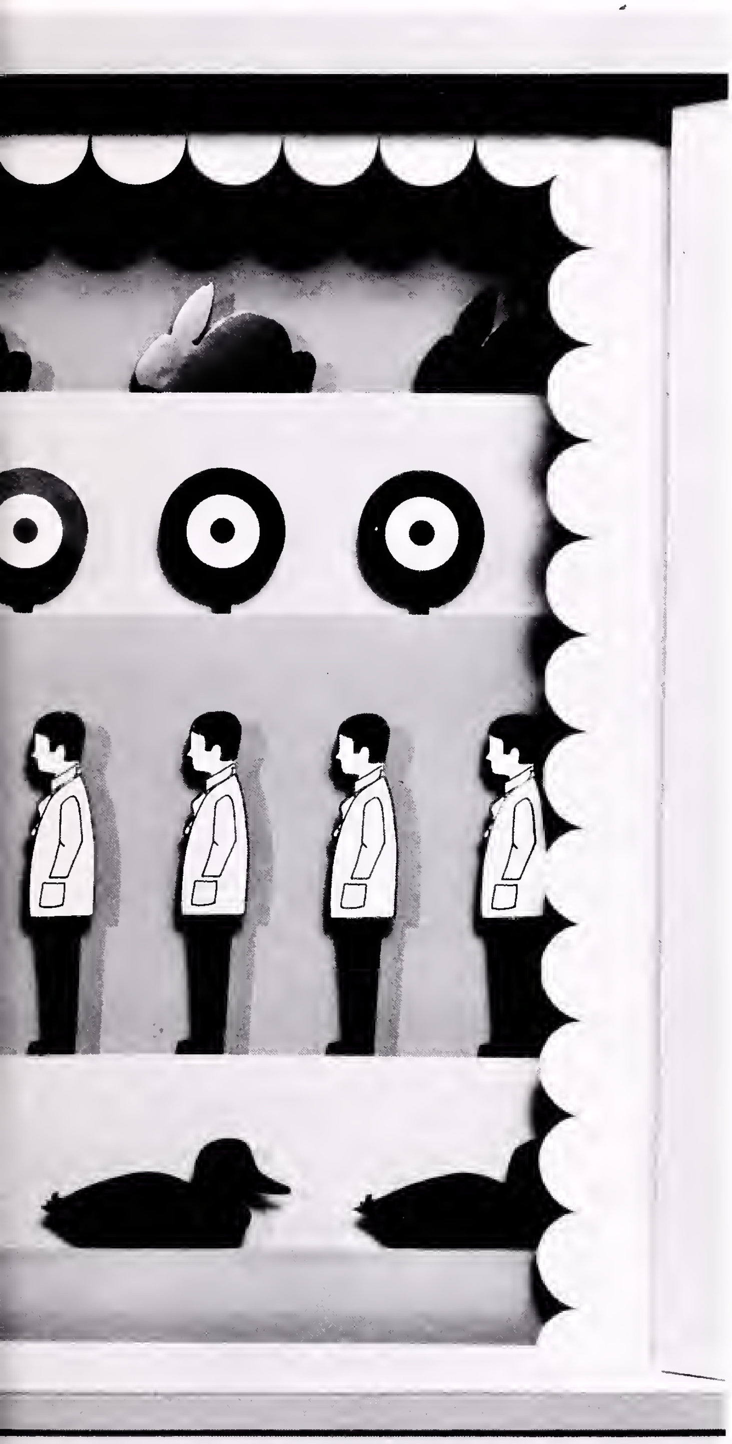
ANDROID®/F
Fluoxymesterone U.S.P. Tablets, 10 mg.

If you become the target of a



©1983 MPMLC

professional liability claim...



You will be glad you have Michigan Physicians.

Michigan Physicians has been solving complex medical professional liability problems since 1976. With the state's largest and most experienced claims staff, Michigan Physicians works with you to resolve claims (and incidents) that most physicians have never faced in their careers.

In a changing legal environment, you need the best coverage you can buy because the risk of a professional liability claim is becoming greater every day.

For a confidential rate quotation and more information about Michigan's leading physician-owned insurance company, call or write the office in your area.

Michigan Physicians
Mutual Liability Company

1305 Abbott Road
East Lansing, MI 48823
(517) 351-1150
(800) 292-1926

6735 Telegraph Road
Suite 205
Birmingham, MI 48010
(313) 647-5550

Endorsed by the Michigan State Medical Society

Doctor . . . examine your front office . . . You'll discover you need to computerize

MEDPAC is the cure

The System That Provides:

- Patient statements, recalls, receipts, reports and aged accounts receivables
- Insurance billings, forms, reports, and BC/BS paperless claims
- Installed by computer professionals who have worked in medical offices

Systems Starting As Low As $12,500.00
on the IBM PC, TELEVIDEO and EAGLE.

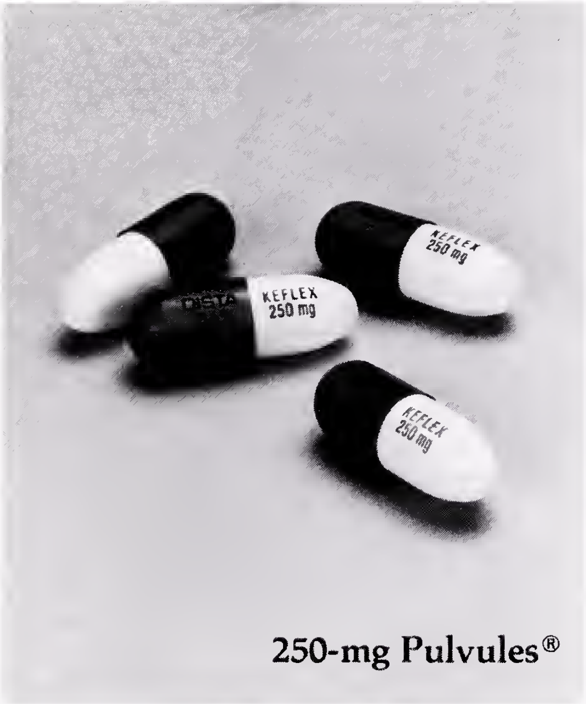
In addition to MEDPAC's standard features, if you place an order during March and April and present this ad, MEDPAC will provide access to GTE TELENET MEDICAL INFORMATION NETWORK (Subscription fee and one year minimum monthly usage charges). TELENET is provided through Physician Service Group, Inc., (Wholly owned subsidiary of the Michigan State Medical Society).

Send the coupon below, or phone us for information:

MEDPAC
Computer Methods Corp.
13740 Merriman Road
Livonia, Michigan 48150
313-522-5187

Dr. ______________________
Address ______________________
City __________ **State** ______ **Zip** ______
Phone ______________________

easy to take


KEFLEX 250 mg
DISTA
KEFLEX 250 mg
KEFLEX 250 mg

250-mg Pulvules®

Oral Suspension

250 mg/5 ml
100 and 200-ml
sizes

125 mg/5 ml
60, 100, and
200-ml sizes

Pediatric Drops

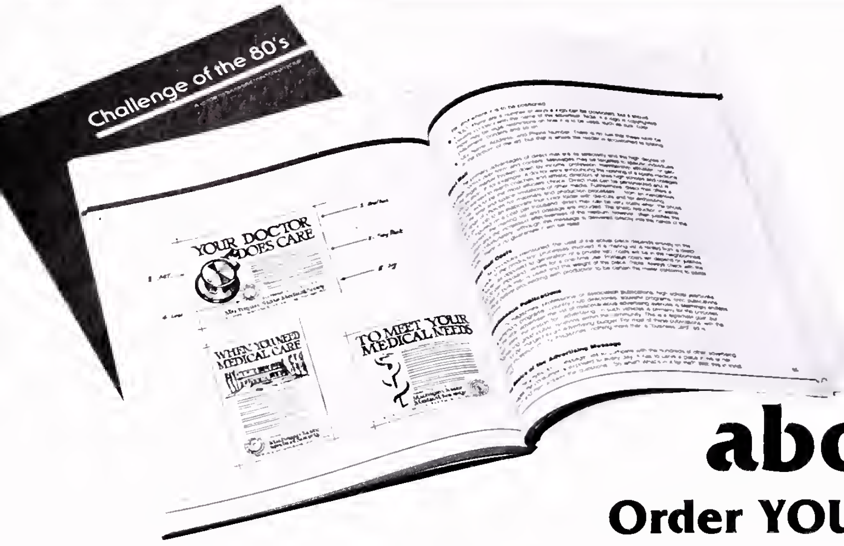
100 mg/ml
10-ml size

Keflex®
cephalexin

Additional information available to the profession on request.

DISTA
000823

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630



Be wise about the 80's

Order YOUR copy of this book today!

The physician is trained for the practice of medicine by years of formal schooling, internship, and residency. But his knowledge of business management and ethical implications is too often obtained by trial and error of experience.

In the years during which I have been exposed to the legal problems of physicians, I have been impressed by the fact that earlier legal advice or even a small measure of business know-how might have avoided an unfortunate situation.

Consequently the section entitled "Ethical and Legal Considerations" of the MSMS booklet *Challenge of the 80s — A Guide to Successful Medical Practice* provides much needed background which should help all physicians recognize common enigmas for which they should seek advice.

Choosing a lawyer, business-related documents including medical records, and responding to lawsuits are by-products of our age of conflict and mistrust. Accuracy in and safekeeping of all records has been emphasized previously but the necessity for confidentiality of medical notes has remained vague in the education of many medical practitioners. It is exhilarating to see a precise two-page statement on this topic in the MSMS guide.

Hospital privileges — access to the doctors' workshop if you will — is an issue which only can be mentioned in the present manual. From the time of Hippocrates, the declared attitude of the profession has always been idealistic, with the assumption that the ideal should be compromised as little as possible. Unfortunately with the advent of regulatory agencies, idealism is almost impossible. The physician must live, and has a debt to his or her family, as well as to society. Therefore rules and customary procedures in day-to-day practice are introduced in the booklet to promote financial success of the practitioner and the dignity of the profession.

It is sad but true that there is a scarcity in libraries and medical education of literature on the subject of ethics. The *Challenge of the 80s* opens the door by emphasizing the mechanics of ethics at both national and state levels.

Challenge of the 80s is a welcome guide to practice — it can be recommended without reservation. A particular, felicitious feature of the section on ethics and law is its tone: kind and considerate — not condescending.

Donald N. Sweeny, Jr., MD, Detroit
MSMS Judicial Commission

Please send me ____ copy(ies) of *Challenge of the 80s: A Guide to Successful Medical Practice.* Enclosed is my check for $____ ($5 x number of copies, or $15 x number of copies if non-member).

Name ________________________________

Address ________________________________

____

City ____________________ Zip ____________

MSMS, 120 W. Saginaw, East Lansing, MI 48823

Competence counts

Hurley Medical Center photo

In selecting a doctor, 74 percent of Americans consider competence, not cost.

Competent doctors remain the key to health. But competence isn't immunity to litigation.

Consider our competence – and our professional liability protection and strong-defense philosophy.

We defend you against non-meritorious claims. We won't settle a claim without your approval or merely to cut our defense cost.

PICOM
Physicians Insurance Company Of Michigan
4277 Okemos Rd., Box 1000
Okemos, Michigan 48864

(517) 349-6500
(313) 557-4845
1-800-292-1036

By Deborah Zannoth

MSMS survey shows malpractice claims trends

MSMS initiated a survey of reported closed malpractice claims in 1975. Since that time a total of 2,907 suits have completed litigation as compared to the total of 2,142 suits we reported last year.

The data presented in this article reflect closed malpractice claims reported by insurance companies doing business in Michigan. The accompanying tables represent reports from companies whose claims have completed the legal system between June 1975 and June 1983.

A total of 765 cases culminated in a judgment during the reporting period of June, 1982 to June, 1983, as compared to 597 over the previous reporting period, June, 1981 to June, 1982. That is an increase of 168 claims or 28% more.

Many of these claims represent suits initiated several years ago, some as far back as 1973. It is apparent that a number of cases initiated during the malpractice crisis of the mid-seventies are just now clearing the system.

A complete accounting of current malpractice claims is presently not compiled by any source in Michigan and, thus, there are limits in compiling malpractice claims data. MSMS receives malpractice statistics only upon completion of litigation, making it difficult to predict future trends with any confidence.

Of the total 2,907 claims processed, the average time between injury and reporting date is 27 months and the average time between injury and closure date is 56 months. The average time between reported date and closure is 29 months. The amount of time between injury and reporting date has increased by four months in the past year, while the time between injury and closure has increased by a month. The time between the reported date and closure has decreased by three months since last year's report (*Michigan Medicine* - January 83).

The average age of the physicians involved has remained at

Table I
Claims Characteristics

Year	Number of Claims	Total Paid	Gross Average Paid	Percent with no Indemnity Paid	Average $ Amount for Claims With Awards
1970	5	$ 16,667	NA	(4) 80%	$16,667
1971	7	$ 52,200	$ 7,457	(3) 43%	$13,050
1972	31	$ 576,762	$18,605	(15) 48%	$36,048
1973	82	$ 801,676	$ 9,776	(35) 42%	$17,057
1974	216	$2,447,484	$11,335	(95) 44%	$20,227
1975	343	$4,627,254	$ 491	(150) 44%	$23,975
1976	386	$6,795,365	$14,811	(146) 38%	$28,314
1977	355	$4,283,930	$12,067	(139) 39%	$19,833
1978	307	$4,212,719	$13,722	(140) 46%	$25,226
1979	313	$6,324,581	$20,200	(126) 40%	$33,821
1980	390	$7,064,305	$18,114	(146) 37%	$28,952
1981	295	$3,884,036	$13,166	(152) 51%	$27,161
1982	164	$1,152,307	$ 7,026	(91) 55%	$15,785

Table II
Distribution by Thousands of Indemnity Paid

Year	0 to 10	11 to 20	21 to 30	31 to 40	41 to 50	51 to 60	61 to 70	71 to 80	81 to 90	91 to 100	101 to 200	201 to 300	301 to 400	401 to 500	Over 500	Total
1970	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	
1971	3	0	0	1	0	0	0	0	0	0	0	0	0	0	0	
1972	5	3	1	0	2	1	2	0	1	0	1	0	0	0	0	
1973	28	8	5	2	2	0	0	1	0	0	1	0	0	0	0	47
1974	73	10	13	4	6	1	1	4	1	8	0	0	0	0	0	121
1975	123	21	12	6	2	3	4	4	0	7	11	0	0	0	0	193
1976	157	22	14	3	7	3	3	4	3	6	14	1	2	1	0	240
1977	156	15	3	8	6	3	4	3	3	10	5	0	0	0	0	216
1978	104	13	11	5	8	1	4	1	2	13	4	1	0	0	0	167
1979	98	11	12	6	13	5	7	8	2	15	9	1	0	0	0	187
1980	136	25	19	15	15	4	4	2	7	10	6	0	0	0	1	244
1981	89	15	5	4	6	2	1	3	5	6	7	0	0	0	0	143
1982	53	7	3	1	3	0	1	1	1	1	2	0	0	0	0	73

Ms. Zannoth is assistant, MSMS Section on Medical Economics and Reimbursement.

46 years for the past two reporting periods. The number of claims with no indemnity paid remains 42 percent, a factor which has been constant for the last four years. Twenty-four percent of the physicians involved have been FMGs. Sixty-eight percent of the practitioners have been board certified and 55 percent are self-employed.

General surgery physicians continue to be involved most often in malpractice litigation, possibly since they are procedure-oriented and exposed more than the average practicing physician.

Data (**Table 1**) show a gradual rise over time in the gross average paid as well as the average dollar amount for claims. Also increasing over the past years are the number of settlements over $100,000.

This report does not represent the entire malpractice picture in Michigan. Data not included are statistics on physicians who are self-insured, hospitals that are self-insured, or physicians self-insured through their hospitals.

Also not accounted for are claims being adjudicated under the Michigan Medical Arbitration Program. The program was initiated on January 1, 1976. As of July 31, 1983, a total of 403 cases were filed, of which 344 have closed and 59 are still pending. Of the 344 closed cases, 67 were withdrawn, 136 were settled and 66 were administratively closed. In 75 of the cases an award was made. (Please see accompanying article in this issue, page 136.)

In the 75 cases where an award was made, 22 were in favor of the claimant(s) and 53 were in favor of the respondent(s).

MSMS would like to thank the Michigan Insurance Bureau and the Department of Licensing and Regulation for their assistance in completing this report.

(Additional tables on claims per capita by physicians and general population are available from the MSMS Section on Medical Economics and Reimbursement.)

Table III
Claims Reporting Data

Years	Number of Cases	Average Number of Months — Injury to Report	Average Number of Months — Injury to Close	Average Number of Months — Report to Close
1970	5	10	85	75
1971	7	11	76	66
1972	31	17	79	61
1973	82	23	75	52
1974	216	21	64	44
1975	343	21	58	37
1976	386	25	58	33
1977	355	27	58	31
1978	307	29	60	31
1979	313	29	56	28
1980	390	30	53	23
1981	295	28	42	15
1982	164	35	41	7

Table IV
Physician Characteristics

Year	Average Age of Physician	Physician Age Distribution					Percent of FMGs	Board Certified
		30 and under	31-40	41-50	51-60	60 and over		
1970	32	25%	25%	50%	0	0	N/A	(4) 80%
1971	39	17%	0	50%	33%	0	29%	(6) 85%
1972	40	0	33%	41%	19%	7%	6%	(20) 65%
1973	39	0	30%	50%	14%	6%	11%	(51) 62%
1974	43	1%	27%	40%	28%	4%	19%	(150) 69%
1975	43	2%	31%	36%	21%	10%	24%	(204) 59%
1976	43	1%	31%	34%	23%	11%	22%	(259) 67%
1977	44	1%	28%	35%	27%	9%	27%	(214) 60%
1978	46	1%	25%	39%	24%	11%	17%	(213) 69%
1979	47	1%	23%	32%	26%	18%	29%	(184) 59%
1980	47	1%	22%	34%	28%	15%	25%	(268) 69%
1981	44	1%	33%	34%	21%	11%	25%	(202) 68%
1982	47	3%	19%	28%	35%	15%	25%	69%

Table V
Claims Against Physicians By Type of Practice

Year	Type of Practice			
	Institutional	PC/ Partnership	Self-Employed	Employed
1970	0	0	5	0
1971	1	2	4	0
1972	1	9	20	1
1973	0	26	51	5
1974	2	75	130	7
1975	2	136	185	17
1976	3	144	220	17
1977	6	121	208	15
1978	0	133	161	10
1979	0	120	174	14
1980	3	190	185	11
1981	2	127	149	13
1982	0	79	75	7

Table VI
Suits By AMA Specialty Classification

General Surgery	969
General Practice	406
Internal Medicine	300
Orthopedic Surgery	291
Diagnostic Radiology	128
Family Practice	84
Pediatrics	61
Neurological Surgery	60
Plastic Surgery	57
Cardiovascular Surgery	51
Anesthesiology	50
Thoracic Surgery	48
Pathology	33
Emergency Medicine	31
Psychiatry	25
Neurology	22
Dermatology	20
Gynecology	20
Otorhinolaryngology	20
Cardiovascular Diseases	15
Pediatric Surgery	15
Ophthalmology	14
Physical Medicine & Rehabilitation	13
Abdominal Surgery	11
Child Neurology	10
Colon and Rectal Surgery	7
Allergy	6
Hand Surgery	6
Gastroenterology	5
Nuclear Medicine	5
Obstetrics	2
Rheumatology	2
Geriatrics	1
Pulmonary Diseases	1
Traumatic Surgery	1
Miscellaneous	117
TOTAL	2,907

Table IX
Others Contributing to Injury

Attending Physician	702
House Staff	352
Nurse, RN	112
Consultant	81
Radiologist	43
Patient	25
Nurse, LPN	14
Radiology Technician	12
Pharmacist	11
Physician's Assistant	10
Anesthesiologist	9
Pathologist	9
Anesthetist	7
Laboratory Technician	6
Aide	4
Physical Therapist	4
Other Technician	3
OR Technician	2
Orderly	1
Maintenance Personnel	1
Administrator	1
Other Personnel	71

Table VII
Geographical Distribution of Claims

Zip Code	Counties Included	Number of Claims
480	Macomb, Oakland, St. Clair	765
482	Wayne	587
481	Livingston, Monroe, Oakland, Washtenaw, Wayne	488
490	Allegan, Barry, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren	159
495	Kent	113
489	Ingham	86
488	Clinton, Eaton, Gratiot, Ingham, Ionia, Isabella, Livingston, Shiawassee	81
485	Genesee	79
492	Calhoun, Hillsdale, Ingham, Jackson, Lenawee	66
486	Arenac, Clare, Gladwin, Midland, Ogemaw, Oscoda, Roscommon, Saginaw	63
494	Mason, Muskegon, Newaygo, Oceana, Ottawa	60
497	Alpena, Charlevoix, Cheboygan, Chippewa, Crawford, Emmett, Luce, Mackinac, Montmorency, Otsego, Presque Isle	51
496	Antrim, Benzie, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Osceola, Wexford	44
498	Alger, Delta, Dickinson, Marquette, Menominee, Schoolcraft	31
484	Genesee, Huron, Lapeer, Oakland, Sanilac	30
487	Alcona, Bay, Iosco, Tuscola	19
493	Kent, Lake, Mecosta, Montcalm	10
499	Baraga, Gogebic, Houghton, Iron, Keweenaw, Ontonagon	9
491	Berrien	3
	Invalid Zip Codes	160
	TOTAL	2,926

Table VIII
Average Indemnity Paid by Zip Code Area

Zip Code	Counties Included	Average Indemnity Paid
488	Clinton, Eaton, Gratiot, Ingham, Ionia, Isabella, Livingston, Shiawassee	$25,162.00
484	Genesee, Huron, Lapeer, Oakland, Sanilac	24,445.00
496	Antrim, Benzie, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Osceola, Wexford	23,141.00
481	Livingston, Monroe, Oakland, Washtenaw, Wayne	17,807.00
485	Genesee	17,565.00
495	Kent	16,992.00
487	Alcona, Bay, Iosco, Tuscola	16,276.00
493	Kent, Lake, Mecosta, Montcalm	14,675.00
482	Wayne	14,646.00
497	Alpena, Charlevoix, Cheboygan, Chippewa, Crawford, Emmett, Luce, Mackinac, Montmorency, Otsego, Presque Isle	13,414.00
489	Ingham	12,228.00
490	Allegan, Barry, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren	12,022.00
480	Macomb, Oakland, St. Clair	11,915.00
491	Berrien	10,941.00
492	Calhoun, Hillsdale, Ingham, Jackson, Lenawee	10,187.00
494	Mason, Muskegon, Newaygo, Oceana, Ottawa	9,999.00
486	Arenac, Clare, Gladwin, Midland, Ogemaw, Oscoda, Roscommon, Saginaw	9,837.00
499	Baraga, Gogebic, Houghton, Iron, Keweenaw, Ontonagon	7,972.00
498	Alger, Delta, Dickinson, Marquete, Menominee, Schoolcraft	5,160.00

Hematology:
Advance Medical & Research Center, Inc. offers the rapidity of automation and internal control parameters required for individual observation of patient results. Specialists in hematology work closely with the pathologist in providing complete and professional followup to our client accounts.

ADVANCE MEDICAL & RESEARCH CENTER, INC.

1270 Doris Rd. • Pontiac, Michigan 48057 • (313) 373-9120

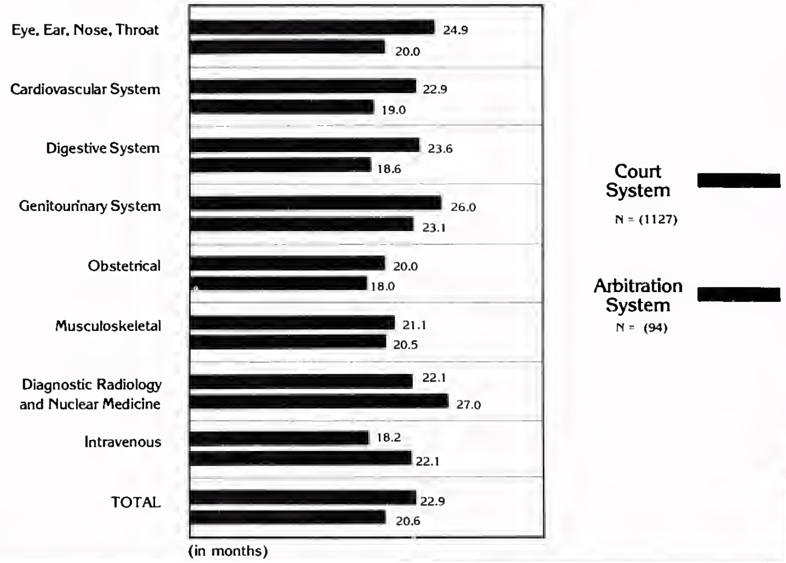
Branches: Allen Park, Alpena, East Jordan, Flint,
Grand Rapids, Kalamazoo, Lansing, Monroe, Traverse City

Serving the medical profession since 1963

Medical arbitration — How the Michigan program measures up

By Rhoda M. Powsner, MD, JD

Table 1 Average Filing to Closing Time Based on Procedure and Forum Type



Arbitration of disputes involving alleged medical malpractice does provide a cheaper and quicker forum for resolving conflicts than does the court/jury system.

That is the conclusion of the Arbitration Advisory Committee after a year of assessment of the statewide program of voluntary binding arbitration as an alternative to litigation. The committee, which was under legislative mandate to evaluate the effectiveness of the program under 1975 Public Act 141, is forwarding its conclusions and recommendations to the legislature.

The committee based its finding on statistical data derived from settled and adjudicated claims, as well as surveys of attorneys, physicians, arbitration panel members and other interested parties.

The committee noted that, due to the impact of constitutional challenges, it could not measure the full extent of the arbitration program's effectiveness. The committee determined, however, that in spite of these obstacles, arbitration has proven to be a viable alternative to litigation.

A full explanation of the committee's review follows:

Data Sources

The committee members compiled data for the study from uniform claims reports, which the insurance bureau requires commercial carriers to submit for each incident of alleged malpractice, and from records of a representative sample of cooperating self insured hospitals, which are not required to submit claims data to the insurance bureau. In addition, we made surveys of attorneys, physicians, arbitrations panel members, hospital personnel offering arbitration agreements, patients and parties to arbitration. The object was to obtain the perceptions of these groups about arbitration as an alternative to litigation. In combination with the statistical information, the group surveys assisted in identifying problems and possible solutions.

Findings

In all, we analyzed 2,611 claims. These cases were opened after January 1, 1976, and closed between June 1, 1978 and June 1, 1982. Of these, 1,159 were disposed of prior to formal filing either in the courts or with the American Arbitration Association. After filing in circuit court, 1,324 were closed; 128 were closed following filing with the Arbitration Association. Sixty-three of the cases filed in court were resolved by formal trial, representing five percent of all claims filed in the courts and two percent of all claims closed in which there was no signed arbitration agreement. The 36 formal arbitration hearings which took place during the study interval constitute 36 percent of all claims filed with arbitration and six percent of all closed claims involving a signed arbitration agreement. Plaintiffs were successful in 27 percent of court trials and 31 percent of arbitration hearings.

Using information from claims data, and employing timeliness,

Continued on page 138

Doctor Powsner is a member of the Arbitration Advisory Committee. She is an Ann Arbor cardiologist, and also serves as an alternate delegate to the AMA.

The AIDS Commitment

AIDS knows its business is serving physicians and their patients, who depend upon our dedication to deliver the best in diagnostic services.

AIDS ensures confidence by providing prompt, accurate and consistent testing services in a wide range of laboratory disciplines.

AIDS strives to conduct all business with integrity, skill and courtesy to each and every client.

AIDS intends to maintain excellence in skills and invest in research and development in order to better serve our clientele in the future.

AIDS understands that good service is the foundation of any business and the best service relies upon having the best people. Our staff of M.D.s, Ph.D.s, highly-skilled technologists and technicians, and AIDS' in-the-field PRO team assures the utmost in dependable, prompt, reliable service.

Allied Integrated Diagnostic Services (AIDS) is Michigan's fastest growing, most progressive full-service clinical laboratory. AIDS comprehensive diagnostic testing comprises a wide range of laboratory disciplines. We are ready to serve your laboratory needs 24 hours a day.

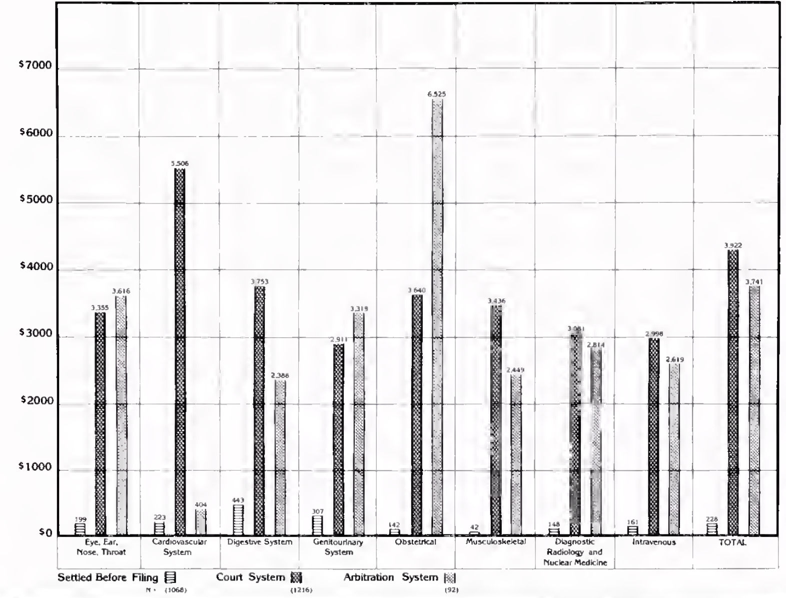
AIDS

ALLIED INTEGRATED DIAGNOSTIC SERVICES
22170 W. NINE MILE ROAD • SOUTHFIELD, MI 48034
313/352-5780
TOLL FREE NUMBER 1-800-AIDS LAB (243-7522)

cost and consistency of awards as standards by which to measure the comparative performances of arbitration and litigation, the committee members characterized arbitration by shorter time from filing to disposition, lower expenses for defense of claims and more consistent awards. **(Figs. 1, 2, 3)**

Table 2

Average Loss Adjustment Expense Based on Procedure and Forum Type



Group survey results of arbitration panel members revealed their perception that the formal arbitration proceedings were extremely fair. Opinions concerning negligence and amount of award were unanimous in 90 percent of the cases. Over 90 percent of physicians surveyed felt arbitration was more impartial than litigation or mediation plus litigation, both of which they perceived to be extremely biased towards plaintiffs.

Among both plaintiff and defense attorneys, arbitration was philosophically felt to be a better forum for defendants, and the court system was considered preferable for plaintiffs. However, the plaintiff bar's contention that arbitration is strongly biased in favor of the health care provider defendant is at variance both with the perception of fairness of arbitration panel members and with statistical data. The fact that arbitration awards generally tend to be lower than those made in court, although they are more consistent for similar injuries, may be the only factor necessary to explain the plaintiff attorney's concern about the fairness of arbitration as a forum. Indemnity payments are higher in those cases resolved through litigation for all categories of claims except major temporary illness or injury. **(Fig. 2)**

The survey of hospital personnel offering arbitration agreements indicates that they have a less than optimal understanding of arbitration as a forum, and that the offering procedures, themselves, may provide less than adequate disclosure concerning the arbitration option. This was of more than passing interest in light of the spate of litigation contesting the validity of signed arbitration agreements. Information obtained from the offering personnel survey provided the basis for the advisory committee's suggested modifications of the present arbitration agreement and the offering process. Some of these are already being put into effect under the current legislation.

Settlements, awards and legal costs showed some difference between metropolitan and outstate areas, but an unexpected finding was the higher legal costs and indemnity payments incurred by self insured hospitals compared to those of the commercially insured hospitals. Legal costs (as defined by defense costs) averaged $250 less per case for commercially insured hospitals than for self insured ($3,822 versus $4,072), and indemnity payments averaged $1,500 less (median value of $1,000 versus $2,524) for the commercially insured than for the self insured.

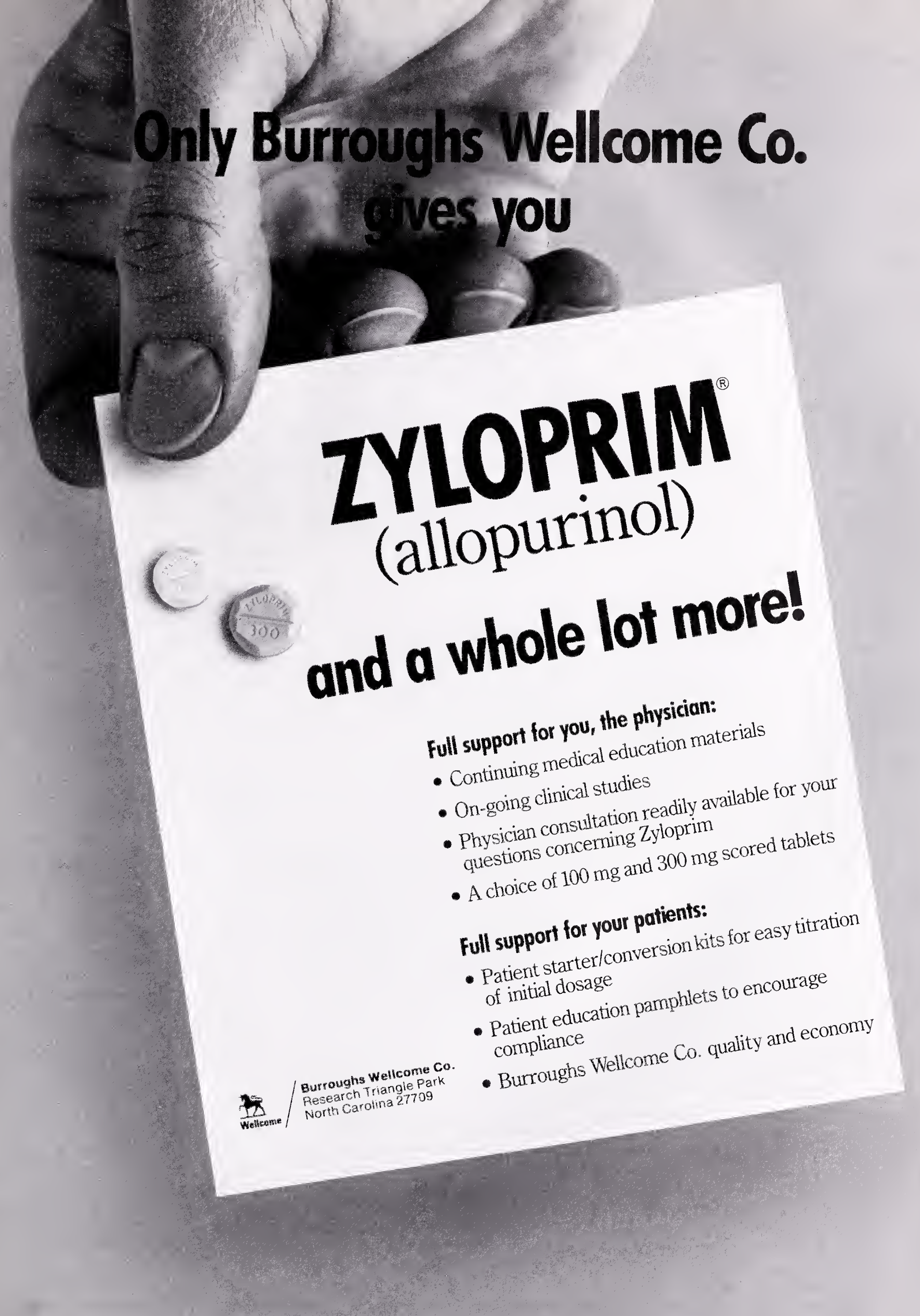
This disparity led to the evaluation subcommittee's recommendation that self insured hospitals be required to disclose their reserving practices just as commercial carriers must. This particular recommendation of the evaluation subcommittee was not adopted by the Arbitration Advisory Committee because a majority of the full committee considered such disclosure an unreasonable intrusion into the business practices of private institutions.

Conclusions

The conclusions of the Arbitration Advisory Committee concerning the Michigan Arbitration Program are as follows:

1. Despite the plaintiff bar's perceptions about bias, arbitration is a fair forum for the disposition of malpractice disputes.
2. Arbitration's performance to date, even under a cloud of constitutional challenges, has shown itself to be a fair, less costly and faster system than the court system for resolution of medical malpractice disputes.
3. The process for offering arbitration agreements needs modification to assure adequate disclosure. With the implementation of these modifications, we expect challenges concerning the validity of individual arbitration agreements to occur with decreasing frequency. That is, if the

Continued on page 140



Only Burroughs Wellcome Co. gives you

ZYLOPRIM®
(allopurinol)

and a whole lot more!

Full support for you, the physician:

- Continuing medical education materials
- On-going clinical studies
- Physician consultation readily available for your questions concerning Zyloprim
- A choice of 100 mg and 300 mg scored tablets

Full support for your patients:

- Patient starter/conversion kits for easy titration of initial dosage
- Patient education pamphlets to encourage compliance
- Burroughs Wellcome Co. quality and economy

Wellcome
Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Michigan Supreme Court does find the program to be constitutional.

Recommendations

The committee's recommendations for changing or modifying the arbitration program include:

1. The arbitration agreement, itself, and the offering process should be revised to assure adequate disclosure and to permit an affirmative declaration by patients to indicate that they understand the major features of the program.
2. Submission of uniform claims reports should be mandated for both commercial insurers and self insured hospitals. At present, self insured hospitals are not required to submit these forms. The insurance bureau should systematically analyze medical malpractice claims data on a statewide basis. Such an analysis would assist not only in ascertaining the actual costs incurred by insurers, but also in gaining an understanding of the reasons for the apparently significant discrepancy in defense costs and payouts between commercially insured and self insured hospitals.
3. There is no reason to presume bias on the basis of the composition of the arbitration panel, which includes one attorney, one health care provider and one public member. The advisory committee, feeling that the presently constituted panel is fair and more likely to be superior to any other constituted panel, declined to offer an alternate panel composition should the Supreme Court find the present composition grounds for declaring arbitration to be unconstitutional.
4. Because the incidence of alleged malpractice occurrences is only 15 percent in hospital outpatient areas and four percent in emergency rooms, hospitals should be given the option of whether or not to offer arbitration agreements in these areas. At the present, offering in both areas is mandated by law. This recommendation would permit individual institutions to determine if the arbitration program is cost effective for areas other than those in which inpatient care is provided.
5. The Michigan Malpractice Arbitration Program should not be retained unless it is supported by a significant majority of all health care providers. If retained, self insured as well as commercially insured hospitals should be required to participate.

Both the Arbitration Advisory Committee's report, as well as the full report of the evaluation subcommittee as researched and compiled by Applied Social Research, Inc., will be forwarded to the legislature at the next session. The Michigan Hospital Association and the Physician Crisis Committee have asked to have their minority reports included in the full advisory committee's communication to the legislature.

Commentary

To aid in understanding the impact of this legislation, it is worthwhile to briefly review the circumstances that surrounded the statewide adoption of voluntary binding arbitration.

Aware of the impending medical malpractice "crisis" as early as 1968, Jack Dodge, a Detroit attorney and labor arbitrator, speaking before the Michigan Neurosurgical Society, suggested arbitration as an alternate mechanism to the court system.

When, in 1974, the impending crisis actually materialized, the Physician's Crisis Committee was formed; its membership was composed primarily of surgeons, surgical subspecialists, and anesthesiologists. Jack Dodge was its tactition.

The Crisis Committee was the catalyst that brought together the diverse groups which formed the medical malpractice coalition for the purpose of obtaining legislation to solve the malpractice problem. The coalition's original members included the UAW, the Teamsters, the Michigan Catholic Conference, the Michigan Chamber of Commerce and the Physician's Crisis Committee. Douglas Fraser, of the UAW and Ed Farhat of the Michigan Catholic Conference were the co-chairmen. Once the coalition's activities began in earnest, the Michigan Hospital Association, the Michigan State Bar, and the Michigan State Medical Society joined in the negotiations surrounding the legislative process.

It was not an easy time for anyone. Michigan physicians, as well as Michigan lawyers, were polarized from within as well as externally. It is a tribute to the negotiating skills of committed members of each profession and the stewardship of their leaders that the passage of this legislation did not irrevocably tear the professional community asunder. Nevertheless, early opposition to arbitration, especially on the part of the hospital community and the malpractice plaintiff bar, has not abated, and its effect on the program has been considerable.

The plaintiff bar has raised a constitutional challenge to the arbitration program, alleging bias of the three-member arbitration panel, which includes one attorney, one public member and one health care provider. The physician's or institutional provider's capacity for fairness is said by the plaintiff's bar to be impaired by the fact that a decision for the plaintiff in any given arbitration would necessarily result in an increase in professional liability premiums for the health care provider community as a whole.

Why bias was imputed to the health care provider only is really not clear, nor does the reason for the challenge seem particularly compelling. If the relationship between the outcome of a single arbitration and provider liability premiums is found by the Michigan Supreme Court to be close enough to constitute a conflict of interest for the provider panel member, it would follow that the financial interests of the attorney member vis a vis the overall effect of a finding for plaintiff on the occurrence and size of future awards also would bear scrutiny, as the granting and amount of

Continued on page 142

Medical Data Services - Texas Instruments

Working Together To Make Your Practice $UCCESSFUL

MDS, the nation's leading specialist in the business management of **MEDICAL PRACTICES,** has joined with **TEXAS INSTRUMENTS,** the leader in sophisticated computer systems, to provide private physicians with a state-of-the-art, user-friendly, low cost medical billing-accounts receivable management system.

To be more $uccessful **CALL TODAY** for a no-obligation proposal for your practice.

Toll Free in Michigan 1-800-482-6972

TEXAS INSTRUMENTS
COMPUTER SYSTEMS

MEDICAL
DATA
SERVICES

5420 HILL-23 DRIVE
FLINT, MICHIGAN 48507

1-800-482-6972 **313-238-1666**

Medical Data Services is a subsidiary of Charter Medical Corp.

Figure 1
Claim Disposition Characteristics by Forum

	Settled Before Filing	Filed with Arbitration	Filed with Court
Cost of Claim Defense	**$228.85**	**$3,652.50**	**$3,914.60**
Median Payment	**$0**	**$1,000.00**	**$1,875.00**
Time Filing to Closing	**—**	**20.2 months**	**22.8 months**
Total Cases	**1,159**	**128**	**1,324**

awards have an impact on plaintiff attorney remuneration.

At the moment, the future of the Michigan Arbitration Program lies with the Michigan Supreme Court. It is significant that arbitration has performed so well in an essentially hostile milieu created by the opposition of the plaintiff's bar and a good portion of the hospital community. Also, general physician apathy has not enhanced acceptance of arbitration. This apathy, interestingly, belies what appears to be a positive perception by physicians of arbitration's value. Perhaps most surprising is the fact that the member of the Arbitration Advisory Committee originally representing the Physician's Crisis Committee, which was so instrumental in obtaining passage of this innovative legislation, has vigorously opposed those recommendations which are most necessary to assure adequate disclosure and, therefore, the validity of signed arbitration agreements. This opposition to appropriate modifications appears to be based on two premises: first, that anything which modifies the original legislation is unacceptable; and second, that hospital opposition to the program can only be expected to become greater if any changes are made. Neither contention survives even superficial scrutiny. Unfortunately, however, the alliance between the hospital community as a whole and the Physician's Crisis Committee allowed for less than optimal discussion of several of the issues raised in the course of the evaluation.

It is obvious that even if the Michigan Supreme Court finds the Michigan Malpractice Program to be constitutional, it will not achieve importance ever as an alternative to legislation unless a significant majority of physicians and other professionals, as well as institutions providing health care services, actively support it. As there are a very few viable solutions being put forward to resolve the continuing problems posed by the increasing number and size of malpractice claims, it would seem that the medical community has enough of a stake to become actively involved in promoting arbitration as an alternative to litigation, pending the Court's determination.

Do you know

a physician
with problems
of alcoholism,
drug abuse,
emotional illness
or other
difficulties
which interfere with
his or her ability
to practice medicine?

If so, please contact your MSMS Program to Assist Impaired Physicians through Katie Brewbaker at MSMS headquarters, (517) 337-1351.

By Clarice James

Here's how AMA-ERF funds are used

Marian Monnahan, national AMA-ERF chairman, submitted the following article for the AMA-ERF Committee Newsletter this October. "Many auxilians have asked how the funds given to the medical schools are used by the deans. Last November, this committee sent a letter to medical school deans. Over half responded, and a statistical report was compiled to show how these funds are used.

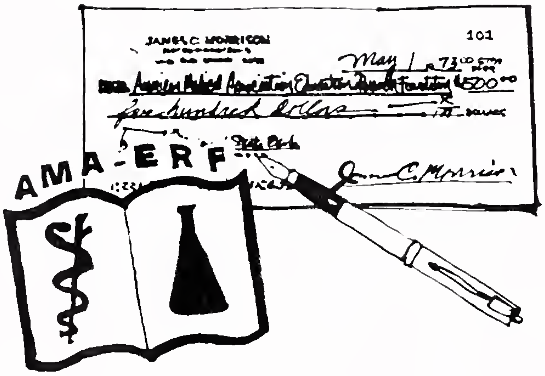
- **"Twelve deans reported** their schools use the funds strictly for scholarships, loan programs, and aid for needy students.
- **"Nine said they split the money** between student loans and student activities which include emergency short-term loans, interviews, and the printing of publications.
- **"Two schools use the money** entirely for the medical school library.
- **"Four divide funds** between student activities and school programs which cover tutoring and teaching aids for students, faculty retention, and curriculum evaluation.
- **"Student research programs** benefited at another two schools."

Students are indeed receiving the benefits from these unrestricted funds. In responding, each dean expressed concern for students' futures as costs continue to escalate. Deans conveyed gratitude for AMA-ERF funds. With ever-shrinking budgets, many of the student services and programs would be impossible without these funds. And now it is becoming more difficult as many deans are finding it necessary to use funds for emergency loans. We will all be winners when we continue to support medical education with our dollars.

Contributions to AMA-ERF have been received from the following Michigan counties: Bay, Arenac, Iosco; Calhoun; Genesee; Grand Traverse, Leelanau, Benzie; Ingham; Jackson; Kent; Macomb; Midland; Monroe; Muskegon; Saginaw; Washtenaw; Wayne. These funds were raised through the holiday sharing card, holiday card commissions, memorials, sales of note pads and stationery, auctions, watch sales, jewelry sales, Kentucky Derby party, lobster sales, and contributions.

I would like to thank the AMA-ERF county chairpersons and their respective counties for doing an excellent job in raising funds for AMA-ERF. The need is greater this year, and your *extra effort* in obtaining contributions is greatly appreciated by the medical schools and their students.

Mrs. James is MSMS/AAMA-ERF chairperson for the MSMS Auxiliary. She lives in Flint.



Membership's infectious

By Cathie L. Martin

In recent issues of *Michigan Medicine,* board members of the Michigan State Medical Society Auxiliary have commented on various aspects of the auxiliary. As I am chairperson of the Membership Committee, I would like to address the question of your spouse's membership in our organization. This is a timely subject as the Michigan State Medical Society is conducting its membership drive now and you are once again recommitting yourself to its goals and endeavors.

The MSMS Auxiliary is, in effect, a mirror image of your commitment. MSMS/A is a complement to one of the finest medical societies in the country.

Certainly, — you are a member — you don't have to be persuaded. But is your spouse a member?

Let MSMS/A provide for your spouse the same high standards of good medical-community relations, legislation, health projects and medical school aid that you've come to expect from MSMS.

We've all heard of "infectious laughter." Well, I want your membership in MSMS to spread a little and "infect" your spouse. Face it — the physicians in this state have a good thing going for them — 10,000 plus members can't be wrong. So spread the good news when you go home tonight and help "make membership infectious!"

Ms. Martin is MSMS/A vice president. Her husband, David, is a specialist in infectious diseases who practices in Traverse City. She is the business manager for her husband's practice, owns a consulting service and has two daughters.

David B. Davis, MD
Grand Rapids
David B. Davis, MD, Grand Rapids, died November 21. He was 81. Doctor Davis helped establish the first psychiatric unit in an acute care hospital in the state. He headed that unit at Butterworth Hospital until 1962 when he became director of the Kent Oaks Hospital. He held that post until he retired in 1965. A 1921 University of Michigan Medical School graduate, Doctor Davis also served in World War II.

William L. Deutsch, MD
Franklin
William L. Deutsch, MD, Franklin, age 68, died on December 24. Doctor Deutsch practiced medicine in Royal Oak for 40 years before retiring last year. He served on the staffs of Sinai Hospital and St. Joseph's Mercy Hospital. He was a 1940 graduate of the University of Michigan Medical School.

Paul A. Dosch, MD
Grayling
Paul A. Dosch, MD, Grayling, died on January 4, at the age of 54. He was a 1953 graduate of Loyola University Medical School. Doctor Dosch practiced family medicine in Grayling for the last 27 years, opening his own Family Practice Clinic in 1969.

Prepare For:

- TOEFL
- MSKP
- NATIONAL MEDICAL BDS
- VQE
- ECFMG
- FLEX
- DENTAL BDS
- PODIATRY BDS
- NURSING BDS

- Voluminous home study notes on all areas of basic science.
- Teaching tests accompanied by comprehensive teaching tapes to be used at any of our tape centers.
- Materials constantly updated.
- Over 40 years of experience and success in the field of test preparation.

Stanley H. KAPLAN
EDUCATIONAL CENTER

For information Please Call:
Ann Arbor (313) 662-3149
Detroit (313) 569-5320
E. Lansing (517) 332-2539
Centers in More than 115 Major U.S. Cities, Puerto Rico and Toronto, Canada

Watson A. Gilpin, MD
Troy
Watson A. Gilpin, MD, Troy, age 67, died on December 17. Doctor Gilpin received his medical degree from Wayne State University School of Medicine and served his residency in internal medicine at Henry Ford Hospital. He practiced in Troy and served on the staff of several Detroit hospitals.

Leonard A. Ginnebaugh, MD
Grosse Ile
Leonard A. Ginnebaugh, MD, Grosse Ile, died December 11 at the age of 57. Doctor Ginnebaugh served on the staff of the former Fort Custer State Home and Training School. For the past 10 years he had been a pathologist at Wyandotte General Hospital. He graduated from the University of Michigan Medical School and served his internship at St. Mary's Hospital in Grand Rapids.

Dewey R. Heetderks, MD
Boca Raton, FL
Dewey R. Heetderks, MD, formerly of Grand Rapids, died December 11 at the age of 87. Doctor Heetderks was a graduate of the University of Michigan Medical School and practiced ear, nose and throat medicine in Grand Rapids for over 40 years. He had resided in Florida for the past 13 years.

Marion W. Jocz, MD
St. Clair
Marion W. Jocz, MD, St. Clair, died November 19 at the age of 76. Doctor Jocz was a fellow of the American College of Chest Physicians, American College of Preventive Medicine and the Industrial Medical Association. He was also the recipient of an award for health achievement in industry by the Industrial Medical Association. He was executive medical director at Chrysler. Doctor Jocz was a Wayne State University School of Medicine graduate.

Lewis D. Kaufman, MD
Flint
Lewis D. Kaufman, MD, Flint, age 70, died on December 28. Doctor Kaufman practiced medicine in Flint for 46 years before retiring on March 1, 1983. He was a University of Michigan Medical School graduate and served in World War II. Doctor Kaufman contributed a Medical Library at Israel Medical Society in Jerusalem.

Albert H. Keefer, MD
Concord
Albert H. Keefer, MD, Concord, died on December 19 at the age of 73. He received his degree from the University of Michigan Medical School and interned at Hammet Hospital, Erie, PA. His general practice office was opened in Concord in 1937 where he practiced until 1980.

Edward W. Krass, MD
Grosse Pointe Shores
Edward E. Krass, MD, Grosse Pointe Shores, died December 3. He was 81. Doctor Krass was a graduate of the Detroit College of Medicine and Surgery in 1930 and completed his residency at Providence Hospital. He was the former chief of surgery at St. John Hospital and was on staff there since 1952.

Frederick P. Maibauer, MD
Riverview
Frederick P. Maibauer, MD, Riverview, died December 5 at the age of 75. He practiced medicine in Wyandotte for 45 years and was past chief of surgery and past chief of staff of Wyandotte General Hospital. Doctor Maibauer was a Western Reserve Medical School graduate and retired in 1974.

Wayne O. Martin, MD
Grand Ledge
Wayne O. Martin, MD, Grand Ledge, died at the age of 77 on October 31. He was a 1973 graduate of the University of Michigan Medical School. Doctor Martin was director for 30 years of the medical program at Motor Wheel in Lansing.

Peter L. McGee, MD
Bay City
Peter L. McGee, MD, Bay City, died November 15. He was 60. Doctor McGee was chief of staff at Bay Medical Center from 1972 to 1974 and practiced general surgery in Bay City for 26 years. He was a graduate of the University of Michigan Medical School, and trained in surgery at Wayne State University.

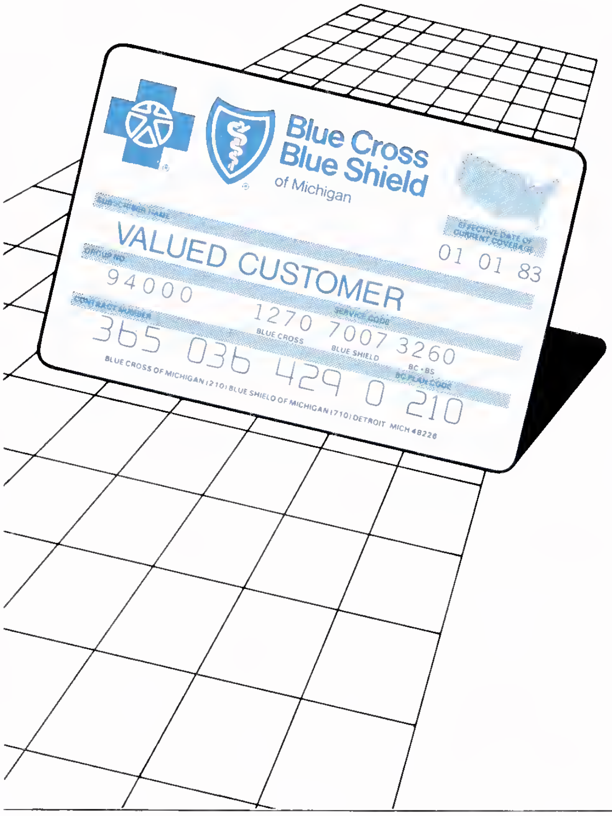
Leo T. Moleski, MD
Grand Rapids
Leo T. Moleski, MD, age 72, died on December 12. Doctor Moleski was a lifelong resident of Grand Rapids, where he practiced medicine for over 45 years. He was a graduate of Loyola University medical school and a veteran of World War II.

Harry M. Nelson, MD
Bloomfield Hills
Harry M. Nelson, MD, Bloomfield Hills, died on December 7. He was

Continued on page 146

DIMENSION III

LOW-COST HEALTH CARE COVERAGE FROM BLUE CROSS AND BLUE SHIELD OF MICHIGAN.



Now there's a new low-cost health care plan for Michigan State Medical Society members and their employees. It's Dimension III from Blue Cross and Blue Shield of Michigan . . . a health care plan in which the subscriber shares in the cost of the covered services. Dimension III is a lower cost alternative to the other health care plans presently available to doctors and their employees. Here's how the plan works.

Dimension III for doctors:
Deductible — $ 500 one person
$1,000 family

Dimension III for employees:
Deductible — $100 one person
$200 family

Once the deductible amount has been met, Dimension III pays 80% and the subscriber pays a 20% copayment for covered health care services. When the subscriber has paid $1,000 in copayments, no further copayments are required. Dimension III pays 100% up to $1 million. And when you select one of these plans, you'll get all the benefits that characterize the best health care coverage available:

☐ Hospital care benefits.
☐ Surgery.
☐ Maternity care.
☐ Outpatient care benefits.
☐ Psychiatric care benefits.
☐ The I.D. card that's recognized everywhere.
☐ A minimum amount of paperwork.
☐ A statewide network of Blue Cross and Blue Shield Service Centers to assist you and your employees.
☐ Worldwide coverage for you and your family.

Blue Cross and Blue Shield coverage is the choice of over 5 million Michigan residents. Why not make it your choice, too?
For enrollment information, call your local Blue Cross and Blue Shield of Michigan representative.

CAN YOU REALLY AFFORD ANYTHING LESS?

Blue Cross
Blue Shield
of Michigan

88. Doctor Nelson graduated from the University of Michigan Medical School in 1920 and served as chief of gynecology at Women's Hospital in Detroit. Doctor Nelson founded a number of cancer fighting organizations, including the Southeastern Michigan Division of the American Cancer Society.

Burton E. Phillips, MD
Detroit
Burton E. Phillips, MD, Detroit, died on October 31 at the age of 64. A 1944 Howard University School of Medicine graduate, he was active on the staffs of Harper-Grace, Providence, Mt. Carmel Mercy and Receiving hospitals in the Detroit area. Doctor Phillips was awarded the Bronze Star for distinguished service as chief of otorhinolaryngology at Army Hospital in Yokohama, Japan.

Arthur M. Rothman, MD
Mt. Clemens
Arthur M. Rothman, MD, Mt. Clemens, age 79, died on October 3. Doctor Rothman graduated from the Detroit College of Medicine in 1927 before opening his practice in East Detroit. He had been on the staff of St. Joseph Hospital for more than 50 years, serving as chief of staff and head of the obstetrics and gynecology departments. During his career Doctor Rothman delivered more than 5,000 babies.

Ray E. Newton, MD
Jackson
Ray E. Newton, MD, Jackson, died on November 16 at the age of 89. Doctor Newton practiced medicine in Jackson for more than 50 years before retiring in 1974. He was a 1924 graduate of the St. Louis University School of Medicine and served in World War I.

Ernest L. Overbeek, MD
Grand Rapids
Ernest L. Overbeek, MD, Grand Rapids, age 62, died on November 17. He practiced in Grand Rapids for more than 30 years before retiring five years ago. Doctor Overbeek was a graduate of Hope College and the University of Michigan Medical School.

Heinz G. Simon, MD
Grosse Pointe Shores
Heinz G. Simon, MD, Grosse Pointe Shores, died December 15 at the age of 74. He served on the staffs of Deaconess, St. John and Cottage hospitals before retiring in 1974. A graduate of Wayne State University School of Medicine, he was a charter member of the American Academy of Family Practice.

Lloyd H. Smith, MD
Ludington
Lloyd H. Smith, MD, Ludington, age 52, died on December 2. Doctor Smith was in the family medical practice in Indiana for 16 years before moving to Southern Illinois University to do clinical work at the Student Health Service. In 1977 he moved to Ludington where he became the emergency room doctor at Memorial Medical Center of West Michigan. Doctor Smith received his medical degree from the Indiana University Medical School.

E. C. Vonder Heide, MD
St. Clair Shores
E. C. Vonder Heide, MD, St. Clair Shores, died on December 4. He was 82. After graduating from the University of Michigan Medical School in 1928, he went into private practice and served on the staffs of several Detroit hospitals. Doctor Vonder Heide received a distinguished service award, presented by President Lyndon Johnson, from the Michigan Chapter of the Arthritis Foundation.

How to reduce your accounts receivable without lifting a finger.

If your accounts receivable look like the National Debt, don't blame the economy entirely. Your billing system might be part of the problem. Late statements mean late collections. Error-prone or ambiguous statements collect complaints instead of cash.

The Control-o-fax Statement Service eliminates these problems. This service gets your billing out on time every time. And each statement is the exact "picture" copy of your ledger card.

Our Control-o-fax Statement Service clients have reduced their accounts receivable significantly without lifting a finger. Call for full details.

Detroit Area:
Creative Systems, Inc.
19675 W. Ten Mile Rd.
Southfield, MI 48075
(313) 352-9425

Control-o-fax®
STATEMENT SERVICE

Outstate Michigan:
Reed Office Systems, Inc.
2121 Three Mile Road, N.W.
Grand Rapids, MI 49504
(616) 784-4755
LANSING 482-0200 FLINT 238-7447
TRAVERSE CITY 941-7771
SAGINAW 752-8802

"A New Dimension in the Treatment of Alcoholism and Drug Dependency"

NAPLES RESEARCH & COUNSELING CENTER

Offering Multi-Program Approaches for Individuals and Families Suffering from

- Alcoholism
- Drug Dependencies
- Life Adjustment
- Food Addiction

Our professionally staffed JCAH approved chemical dependency program is covered by CHAMPUS and most other group health care plans.

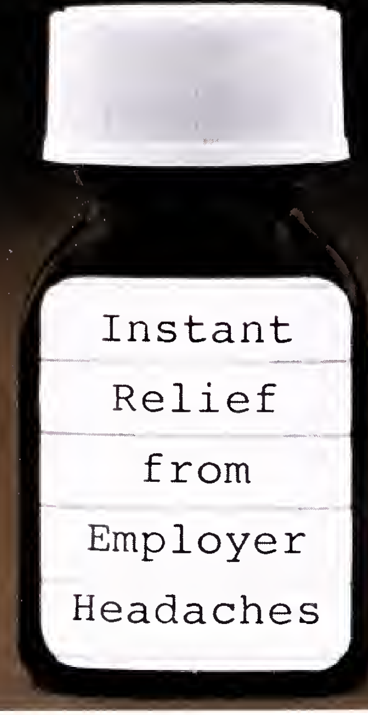
CALL US TODAY for a Confidential Evaluation or Intervention Assistance
(813) 775-4500

9001 Tamiami Trail East, Naples, Florida 33962
An Affiliate of The Palm Beach Institute Family of Programs, Incorporated

SSTAF

Staffing Service To American Free-enterprise

Employee Leasing



Find out how Employee Leasing can create a more lucrative pension plan for you, while lowering your management costs and improving employee benefits and job security. Write for FREE brochure, today!

I want to know more about SSTAF:

NAME ____________________

ADDRESS ____________________

CITY __________ STATE ______ ZIP ______

SSTAF

Mail to:
Staffing Service To American
Free-enterprise
2095 Niles Road, St. Joseph, MI 49085 (616) 983-1558
Corporate Headquarters: P.O. Box 1620, Charlotte Amalie, U.S. Virgin Islands 00801

References:
1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104 672-681, September 1982
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm. Experience in 127 patients *N Engl J Med* 302 1269-1273, June 5, 1980.

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. **Vasospastic Angina**: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e g , where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and or adequate doses of beta blockers

II. **Chronic Stable Angina (Classical Effort-Associated Angina)**: PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and or organic nitrates or who cannot tolerate those agents

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs (See Warnings)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA

WARNINGS: **Excessive Hypotension**: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers

Severe hypotension and or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina probably related to increased sensitivity to catecholamines Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation It is important to taper beta blockers if possible rather than stopping them abruptly before beginning PROCARDIA

Congestive Heart Failure: Rarely patients usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA Patients with tight aortic stenosis may be at greater risk for such an event

PRECAUTIONS: **General**: **Hypotension**: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested Close observation is especially recommended for patients already taking medications that are known to lower blood pressure (See Warnings)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA This edema occurs primarily in the lower extremities and usually responds to diuretic therapy With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction

Drug interactions: Beta-adrenergic blocking agents (See Indications and Warnings) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina

Long-acting nitrates PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination

Digitalis Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers The average increase was 45% Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured digitalis toxicity was not observed Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization

Carcinogenesis, mutagenesis, impairment of fertility When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose

Pregnancy Category C Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats mice and rabbits, and abnormalities in monkeys

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema nausea, weakness, headache and flushing each occurring in about 10% of patients transient hypotension in about 5%, palpitation in about 2% and syncope in about 0 5% Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication Additionally, the following have been reported muscle cramps, nervousness dyspnea, nasal and chest congestion, diarrhea constipation, inflammation, joint stiffness, shakiness, sleep disturbances blurred vision, difficulties in balance, dermatitis pruritus urticaria, fever, sweating, chills, and sexual difficulties Very rarely introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension

In addition more serious adverse events were observed not readily distinguishable from the natural history of the disease in these patients It remains possible, however, that some or many of these events were drug related Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2% Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0 5% of patients

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK LDH, SGOT, and SGPT have been noted and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy The relationship to PROCARDIA therapy is uncertain These laboratory abnormalities have rarely been associated with clinical symptoms Cholestasis possibly due to PROCARDIA therapy has been reported twice in the extensive world literature

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66) 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41) The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77° F (15° to 25°C) in the manufacturer's original container

More detailed professional information available on request © 1982, Pfizer Inc

Pfizer **LABORATORIES DIVISION**
PFIZER INC

"I can do things that I couldn't do for 3 yrs. including joining the human race again."

Quotes from an unsolicited letter received by Pfizer from an angina patient.
While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

© 1983, Pfizer Inc.

"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).

for the varied faces of angina

PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

*Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA *brief summary on adjoining page.*

Motrin®
ibuprofen, Upjohn
600 mg Tablets

MOTRIN
600 mg

More convenient for your patients.

Upjohn

©1984 The Upjohn Company

The Upjohn Company • Kalamazoo, Michigan 49001 USA

J-4044 January 1984

MSMS, MSMS/A, AMA, and medical assistants

March 28-29 — Maternal Health Conference, Hyatt Regency Dearborn, contact: Katie Brewbaker, MSMS headquarters.

April 12 — Sports Medicine Conference, Long's of Lansing, contact: Mert Scholten, MSMS headquarters.

April 26-29 — Annual convention, American Association of Medical Assistants, Michigan State Society, Lansing Hilton Inn, contact: Meridee Gerger, CMA-AC, at 517/485-2130.

May 4-6 — MSMS House of Delegates Meeting, Amway Grand Plaza Hotel, Grand Rapids, contact Warren Tryloff, MSMS headquarters.

May 23 — AMPAC/MDPAC State Political Education Seminar, at MSMS headquarters. Contact: Kevin Kelly, MSMS headquarters.

July 26-29 — Midsummer Meeting, MSMS Board of Directors, Deer Lake, Boyne Mountain, contact: Warren F. Tryloff, MSMS headquarters.

Sept. 19 — MSMS Board of Directors meeting, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Nov. 21 — MSMS Board of Directors meeting, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Other meetings

March 23 — "Creative Pain Management," Lansing General Hospital. Contact: Healthtrak (517) 377-8419.

April 2 — 63rd Annual Beaumont Lecture, John S. Najarian, MD, Minnesota, Speaker. Contact: Wayne County Medical Society headquarters.

April 4 — "Coping with the Stress of Medical Practice," daylong conference on physician stress, sponsored by Wayne County Medical Society Mental Health Committee, at Wayne County Medical Society headquarters, 1010 Antietam, Detroit, contact: Roger Mecum, WCMS executive director, 313/567-1640.

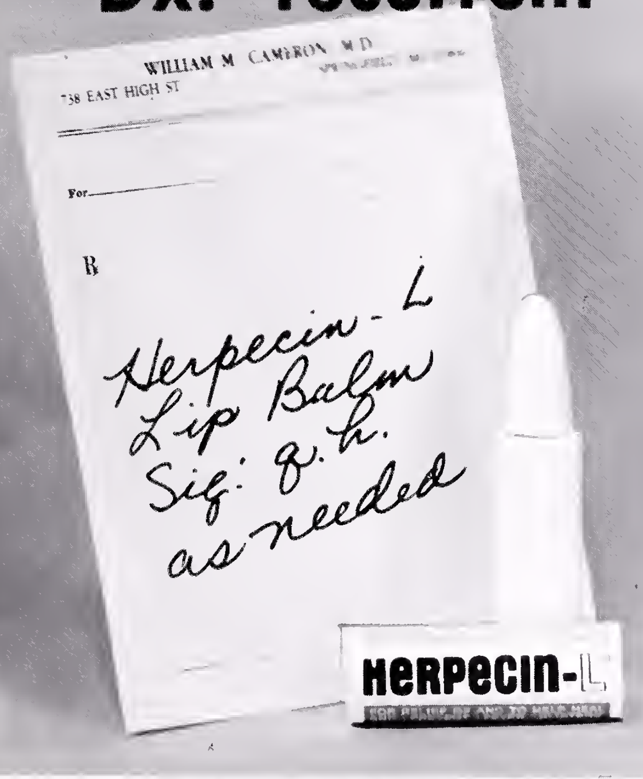
April 4-6 — Michigan Rehabilitation Association 1984 Great Lakes Regional Conference, Marriott Inn, Grand Rapids. Contact: Ms. Sallye McLean at (616) 374-8888.

April 12-15 — "Clinical Applications of Alcoholism Research," Westin Hotel, Renaissance Center, Detroit, contact: American Medical Society on Alcoholism, 733 Third Avenue, 14th Floor, New York, NY 10017 (212) 986-4433.

April 27 — "Empathic Listening: A Program for Clergy and Those Involved in Care for the Dying," Lansing General Hospital. Contact: Healthtrak (517) 377-8419.

June 7-9 — American Hospital Association 7th Annual Trustee Forum, Chicago. For program information, contact: B. Olsen, AHA, (312) 280-6301; for registration, contact: Division of Education (312) 280-6083.

Dx: recurrent herpes labialis



"Herpecin-L Lip Balm is **the treatment of choice** for peri-oral *herpes.*" GP, New York

"In the management of *herpes labialis,* Herpecin-L is a **conservative approach with low risk / high benefit.**" Derm., Miami

"Staff and patients find Herpecin-L remarkably **effective.**" Derm., New Orleans

OTC. See *P.D.R.* for information.
For trade packages to make your own clinical evaluation, write:
CAMPBELL LABORATORIES INC.
P.O. Box 812-M, FDR, NY, NY 10150

In Michigan, "HERPECIN-L" Cold Sore Lip Balm is available at all *Muir, Perry, Revco* and *Sentry Drug Stores* and other select pharmacies.

CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, (517) 337-1351.

Date: March 21, Patient Rights in Health Care Decisions. Location: Borgess Auditorium, Borgess Medical Center, 1521 Gull Road, Kalamazoo 49001. **Sponsor:** Kalamazoo Council for the Humanities and Southwestern Michigan Area Health Education Center. **Contact:** Carol Fites, Kalamazoo Area Council for the Humanities, Kalamazoo College, Kalamazoo 49007, (616) 383-8430. **Approved for:** 2 hours of Category I Credit.

Date: March 25, Arthritis, Collagen Disease and Immunology. Location: Holiday Inn, Mount Pleasant. **Sponsor:** Central Michigan Community Hospital, Continuing Medical Education Program. **For:** General practitioners, internists. **Contact:** Frank D. Johnson, MD, (517) 772-4846. **Approved for:** 7 hours of Category I Credit.

Date: March 28 and 29, Michigan Conference on Maternal and Perinatal Health. Location: Hyatt Regency Dearborn. **Sponsor:** Michigan State Medical Society. **Contact:** Katie Brewbaker, MSMS Headquarters, (517) 337-1351. **Approved for:** maximum of 13 hours of Category I Credit.

Date: March 29-31, Advanced Cardiac Life Support. Location: Bronson Methodist Hospital, 252 E. Lovell, Kalamazoo 49007. **Sponsor:** Southwestern Michigan Advanced Cardiac Life Support Committee and Southwestern Michigan Area Health Education Center. **Cost:** $250.00. **Contact:** Cyndi Kochevar Bouma, Bronson Life Support Office, 252 E. Lovell, Kalamazoo 49007, (616) 383-7576. **Approved for:** 20 hours of Category I Credit.

Date: April 4, Lung Cancer 1984 — State of the Art. Location: Providence Hospital, Fisher Auditorium, 16001 West Nine Mile Road, Southfield, MI 48075. **Sponsor:** Providence Hospital Cancer Committee and the American Cancer Society. **Contact:** (313) 424-3342 Registration Deadline March 21. **Approved for:** 6.5 hours of Category I Credit.

Date: April 4, Current Diagnosis and Treatment in Neurology. Location: Borgess Auditorium, Borgess Medical Center, 1521 Gull Road, Kalamazoo 49001. **Sponsor:** Borgess Medical Center and Southwestern Michigan Area Health Education Center. **Cost:** $85.00 **Contact:** Bill Daam, Neurophysiology Lab, Borgess Medical Center, 1521 Gull Road, Kalamazoo 49001, (616) 383-4895. **Approved for:** 6 hours of Category I Credit.

Date: April 6-7, The Annual Valley Pain Symposium. Location: Sheraton Fashion Square, Saginaw, Michigan. **Sponsor:** Bay Medical Education. **Contact:** James R. Tarrant, Director of Medical Education, 615 Ninth Street, Bay City, Michigan 48706, (517) 892-1501. **Approved for:** 9.5 hours of Category I Credit.

Date: April 9-11, Hemodynamic Monitoring. Location: Towsley Center, Ann Arbor. **Sponsor:** U-M Dept. of Pathology and Office of Continuing Medical Education. **Contact:** Office of CME, Towsley Center, Box 057, U-M Medical School, Ann Arbor, 48109, (313) 763-1400. **Approved for:** 14.5 hours of Category I Credit.

Date: April 12, MSMS Sports Medicine Conference. Location: Long's Convention Center, Lansing. **Sponsor:** Michigan State Medical Society. **For:** MSMS members, college and high school coaches, trainers and others with an interest in the care of athletes and their injuries. **Contact:** Mert Scholten, MSMS headquarters, (517) 337-1351. **Approved for:** 6 hours of Category I Credit.

Date: April 12-13, Seventeenth Annual Cancer Symposium — Acute Leukemia. Location: Harper Hospital, 3990 John R, Detroit. **Sponsor:** WSU School of Medicine, Division of Oncology; Comprehensive Cancer Center of Metropolitan Detroit; and Harper-Grace Hospitals. **For:** Hematologists, oncologists, clinical pathologists, and those in basic sciences. **Contact:** WSU School of Medicine, Division of Continuing Medical Education, 4H University Health Center, 4201 St. Antoine, Detroit 48201. **Approved for:** 10.5 hours of Category I Credit.

Date: April 12-15, Tutorial on Myofascial Release Technique. Location: Kellogg Center for Continuing Education, MSU, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine. **For:** DOs and MDs. **Contact:** Sandy Kilbourn, A306 E. Fee, MSU-COM, East Lansing, 48824. **Approved for:** 24 hours of Category I Credit.

Date: April 16-20, Spring Family Practice Review Course. Location: Towsley Center, Ann Arbor. **Sponsor:** Office of CME, U-M Medical School. **Contact:** Office of CME, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 35 hours of Category I Credit.

Date: April 18, Controversial Infections Diseases. Location: Henry Ford Hospital, Education & Research Bldg. **Sponsor:** Henry Ford Hospital Medical Education Office. **Contact:** Henry Ford Hospital, Medical Education Office, 2799 W. Grand Blvd., Detroit 48202, (313) 876-3073. **Approved for:** 6.25 hours of Category I Credit.

Date: April 18, Institutional Care and Individual Treatment. Location: Gilmore Health Education Center, Bronson Methodist Hospital, 252 E. Lovell, Kalamazoo 49007. **Sponsor:** Kalamazoo Area Council for the Humanities and Southwestern Michigan Area Health Education Center. **Contact:** Carol Fites, Kalamazoo Area Council for the Humanities, Kalamazoo College, Kalamazoo 49007, (616) 383-8430. **Approved for:** 2 hours of Category I Credit.

Date: April 19, Fifth Annual Bronson Nephrology Conference. Location: Gilmore Health Education Center, Bronson Methodist Hospital, Kalamazoo. **Sponsor:** Bronson Nephrology and Southwestern Michigan Area Health Education Center. **Cost:** In Advance: $70; Day of Registration: $80. **Contact:** Charles L. Zeller, Jr., MD, director, Continuing Medical Education, SMAHEC, Stryker Center, 4th Floor, 1521 Gull Rd., Kalamazoo 49007, (616) 388-7881. **Approved for:** 7 hours of Category I Credit.

Date: April 25-26, What's New and Practical in Critical Care. Location: Michigan Inn, Southfield. **Sponsors:** Michigan Committee on Trauma, ACS; WSU School of Medicine; Michigan Society of Critical Care Medicine. **Contact:** Theresa School, WSU Department of Surgery, 6-C UHC, 4201 St. Antoine, Detroit 48201 (313) 577-5009. **Approved for:** 12 hours of Category I Credit.

Date: April 25-26, The Carotid and The Eye. Location: Pontchartrain Hotel, Detroit. **Sponsor:** Harper-Grace Hospitals, Kresge Eye Institute, WSU Department of Surgery and Ophthalmology. **For:** Ophthalmologists, neurologists, vascular and neurological surgeons. **Contact:** WSU School of Medicine, Division of CME, 4H, UHC, 4201 St. Antoine, Detroit 48201 (313) 577-1180. **Approved for:** 9.5 hours of Category I Credit.

Date: May 2, Medical versus Surgical Management of Arterial Problems: A Common Sense Approach. Location: Gilmore Health Education Center, Bronson Methodist Hospital, 252 E. Lovell, Kalamazoo. **Sponsor:** Regional Vascular Surgery, PC, and Southwestern Michigan Area Health Education Center. **Cost:** $80.00. **Contact:** Charles L. Zeller, MD, Director, Continuing Medical Education, SMAHEC, 1521 Gull Road, Stryker Center, Kalamazoo 49001, (616) 388-7881. **Approved for:** 6 hours of Category I Credit.

May 4, Eighth Annual Cardiac Rehabilitation & Exercise Testing Symposium. Location: Borgess Auditorium, Borgess Medical Center, 1521 Gull Road, Kalamazoo, MI 49001. **Sponsor:** Borgess Medical Center & Southwestern Michigan Area Health Education Center. **For:** All physicians. **Cost:** $75.00. **Contact:** Jeffry Morgan, Cardiac Rehabilitation Institute, Borgess Medical Center, 1521 Gull Road, Kalamazoo, MI 49001, (616) 383-8342. **Approved for:** 7 hours of Category I Credit.

Continued on page 157

ELECTIONS '84

In the upcoming 1984 elections Michigan voters will elect a U.S. Senator, 18 Congressmen and 110 State Representatives

MDPAC

MDPAC

MICHIGAN DOCTORS POLITICAL ACTION COMMITTEE

MDPAC *needs* your financial support in order to contribute to the campaigns of candidates responsive to the concerns of the medical profession. It is in the political arena that the major decisions affecting the medical profession are being made. Make a professional membership investment in

MDPAC

An MDPAC investment:

- Reflects physician commitment to political action and results
- Represents a large physician "precinct" motivated to influence the political and legislative processes that affect the practice of medicine
- Provides a coordinated means for medicine to support candidates who recognize and promote the aims of the medical profession

MDPAC Regular Membership	$ 50.00
MDPAC Sustaining Membership	$150.00

(All sustainers receive an MDPAC sustainer pin.)

MDPAC contributions should be written on a personal check

MDPAC, P.O. Box 769, East Lansing, MI 48823

THE MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

1st FOR PROFESSIONAL PROTECTION EXCLUSIVELY

YOUR FIRST STEP TO FIRST QUALITY PROTECTION

CONTACT FIELD REPRESENTATIVES

Eastern Office
RICHARD K. WIND, JOHN K. GALLOWAY, THOMAS A. WEISMAN,
WAYNE M. BACKUS and MARK A. TISDEL
6785 Telegraph Road, Suite 350, Birmingham, Michigan 48010
(313) 647-6640

Western Office
GEORGE J. HAWORTH
2600 Five Mile Road, NE, Suite 101
Grand Rapids, Michigan 49505
(616) 361-0863

LABORATORY OF CLINICAL MEDICINE

MID-MICHIGAN REFERENCE LABORATORY, II, Inc.
(517) 372-8180

1322 E. Michigan Ave.
Suite 211
Lansing, Michigan 48912

930 E. Mt. Hope Ave.
Lansing, Michigan 48910

2909 E. Grand River Ave.
Suite 104
Lansing, Michigan 48912

W. E. Maldonado, M.D.
Director

Robert B. Foy, Ph.D.
Chief Executive Officer

Ann E. Chernys, M.D.
John W. Dyke, Ph.D.
Dennis E. Freer, Ph.D.
John J. Gillespie, M.D.
Ronald N. Horowitz, M.D.
John R. Kateley, Ph.D.

John J. Lyday, M.D.
Joseph R. Melvin, Ph.D.
Sandra K. Shirley, M.D.
Laurence R. Simson, Jr., M.D.
Susan M. Strate, M.D.
Irene K. Trombley, M.D.

REFERENCE LABORATORY FOR SPECIALIZED PROCEDURES
Specimen Pickup and Delivery of Test Results Daily
House calls are available upon Physician's request
Assignment is accepted from Medicare, Medicaid, Blue Shield and all other insurance carriers.

ARIZONA MEDICAL CAREERS
Health Care Industry . . . Sun Valley Country

Our client, a growth oriented, integrated health care organization, with hospitals and clinics in the Southwest, requires Board eligible or certified general practitioners and medical/surgical specialists for new and established practices.

We are particularly interested in physicians for internal medicine, family practice, pediatrics, obstetrics, gynecology, oncology, orthopedics, otolaryngology, general surgery and anesthesiology.

Here is an opportunity to work either in a sophisticated, metropolitan medical environment providing educational and teaching opportunities, or a rural setting offering a substantial practice with outdoor recreational potential second to none.

Sound interesting? Based on your financial needs, our client will offer appropriate income guarantees, incentives, relocation expenses and total malpractice insurance.

Please send your curriculum vitae and professional references.

Suite 311-D
3020 E. Camelback Rd.
Phoenix, AZ 85016

an equal opportunity employer m/f/h

YOUR INCOME
Employees' Salaries
OFFICE RENT
Utilities

COULD YOU MAINTAIN YOUR OFFICE EXPENSES DURING A PERIOD OF DISABILITY?

At age 40, your chances of becoming disabled for up to 6 months are 1 out of 3...1 out of 5 could be disabled up to 2 years...1 out of 7 could be disabled up to 5 years.*

You've probably insured your own income, but what about your employees' salaries, your office rent, your professional liability premiums, etc. etc. Check these features of the Professional Overhead Expense plan sponsored by the MSMS.

- ☑ Up to $3,000 monthly benefit
- ☑ Waiver of Premium
- ☑ Survivors' Benefits
- ☑ Professional liability premiums are a covered expense
- ☑ Expenses covered include rent, utilities, employees' salaries, accountant services, plus many more

"we're here to help"

Stratton–Cheeseman & Associates, Inc.

1305 Abbott Road • P.O. Box 1563 • East Lansing, Michigan 48823
Call Toll Free: **800-292-1966**

*1979. The National Underwriter Company

The rate for each classified advertisement in *Michigan Medicine* is 20¢ per word, with a minimum charge of $10.00. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

Positions Open

GROUP HEALTH, INC., the midwest's largest and oldest prepaid multispecialty group, seeks associates in ALLERGY, CARDIOLOGY, FAMILY PRACTICE (no ob/gyn), GERIATRICS, and OBSTETRICS/GYNECOLOGY. Must be board certified or eligible. Excellent facilities, comprehensive benefits, highly competitive earnings. Send curriculum vitae to: Paul J. Brat, M.D.; Medical Director, GROUP HEALTH, INC., 2829 University Avenue Southeast, Minneapolis, Minnesota 55414.

EMERGENCY PHYSICIANS MEDICAL GROUP: In Grand Rapids, Michigan invites resumés from primary care physicians interested in full-time staffing of a freestanding urgent care facility. We prefer physicians with a background in family practice or emergency medicine who are interested in assuming roles of leadership in the staffing and operation of the facility. Duties will include functioning as an emergency physician, supervising and directing paramedical personnel. Interpretation of radiological, urological and hematological studies. The taking of medical histories and performance of physical examinations. Repair of minor lacerations, immobilization of fractures and sprains. Consult and arrangement for follow-up as appropriate. Requirements for applicants must include a medical degree and licensure in the State of Michigan. Estimated base income will be equivalent to 36 hours per week at $25.00 per hour for an income of $45,000.00 per year. Malpractice insurance is fully paid. Please send your resumé to: 7310 Woodward Avenue, Room 415, Detroit, Michigan 48202, Reference #30883. This is an "Employer Paid Ad."

EMERGENCY CONSULTANTS, INC., is now reviewing applications for full-time and part-time opportunities beginning July 1, 1984. There are limited opportunities available now. Competitive hourly rates in attractive multi-state locations. Malpractice insurance provided; Directorships available. Call today for more information: EMERGENCY CONSULTANTS, INC., 2240 South Airport Rd., Traverse City, MI 49684, Suite 115, 1-800-632-3496.

G.P., FAMILY PRACTICE, INTERNAL MEDICINE, Excellent opportuniy located eighty miles from Detroit, high starting salary, full benefits, paid vacation, holidays, and C.M.E. Monday-Friday, 9-5, no holidays, weekends, or on-site on call. Contact in complete confidence: FRAN PETERS, LaDuke & Associates, Inc., 964 Penobscot Building, Detroit, Michigan 48226, (313) 963-3540.

ORTHOPAEDIC SURGEONS needed for positions throughout the United States. Also, general orthopaedic practice for sales in southern California, financing available. Please contact in confidence: FRAN PETERS, LaDuke & Associates, Inc., 964 Penobscot Building, Detroit, Michigan 48226, (313) 972-6540.

PEDIATRICIAN WITH ONE YEAR NEONATOLOGY TRAINING or Neonatologist to work in a combined Pediatric/Neonatology practice with two other Pediatricians. Immediate position available. Three and one-half year contract with salary of $50,000, $55,000, $60,000, $65,000. Partnership avaialble at end of contract. Call (517) 892-2517.

PEDIATRIC GRAD YEAR II: Very Unexpected opening for July 1, 1984 available in fully approved 3-year program. Contact Saint John Hospital, Department of Health Education, 22101 Moross Road, Detroit, 48236, (313) 343-3875.

THE GRAND RAPIDS DIVISION OF THE DETROIT INDUSTRIAL CLINIC is in need of an additional physician. Preference is for a physician with approximately 5 years practice experience and a background of family practice, surgery, internal medicine, ER, orthopedics or psychiatry. Send CV to R. R. Silver, M.D., Detroit Industrial Clinic, 20755 Greenfield Road, Southfield, Michigan 48075.

PRIMARY CARE PHYSICIANS needed for multi-specialty clinic with family practice base. Need primary care general practice internists and general surgeons. Reply with CV to — Administrator, Redford Medical Center, 25210 Grand River, Detroit, MI 48240.

LANSING: FULL TIME EMERGENCY PHYSICIAN WANTED to complete five man group at 280 bed hospital. Fee for Service with Excellent remuneration. Contact Director, Emergency Department, St. Lawrence Hospital, 1210 W. Saginaw, Lansing, Michigan 48915.

NEW CLINIC OPENING — Position for Family Practice or General Internist. Eight locations. Complete out-patient facilities at multiple locations. Liberal salary, full benefits and physician does his own hospital billing. Call Mary at (313) 921-8080 for appointment.

UNUSUALLY COMPETENT NUCLEAR RADIOLOGIST wishes to relocate to a lakeside community. Send inquiries to Post Office Box 293, Palos Heights, Illinois 60463.

POSITIONS WITH THE STATE OF MICHIGAN — Currently taking applications for positions expected to be available in the future. Office locations now include Kalamazoo, Lansing, Southfield, and Traverse City. A board certified or board eligible psychiatrist needed for the Kalamazoo office, and internists with rheumatology or cardiology background desired for other offices. Beginning salary in low 60s with approximately 26% fringe benefits. An equal opportunity employer. All inquiries treated confidentially. For further details, please write: Harry D. Nesmith, MD, Chief Medical Consultant, Disability Determination Service, PO Box 30011, Lansing, Michigan 48909.

FAMILY PRACTICE (BATTLE CREEK) — Two man family practice seeking one or two physicians doing over $400,000 gross yearly. Serving area of 100,000 with three open hospitals. Salary first year. Full partner after one year. Health insurance, disability insurance, pension and profit sharing plans, six weeks vacation. Inquire to Cinde VanDusen, Capital Avenue Medical, PC, 719 Capital Avenue SW, Battle Creek, MI 49015. Phone (616) 965-5188 (9am-5pm).

GENERAL INTERNISTS AND FAMILY PRACTITIONERS interested in geriatric medicine will find an optimal practice setting in our Sun City, AZ healthcare centers. CIGNA Healthplan, Inc., one of the nation's largest prepaid health plans, offers an opportunity to practice medicine free of the business aspects. Night and weekend call is very light. Competitive salaries. Excellent benefits. Please respond to: Director, Professional Recruitment, PO Box 29030, Phoenix, AZ 85038 (602) 954-3506.

ANESTHESIOLOGIST: Board Certified or Eligible to join CRNA as Chief in a JCAH approved 129-bed hospital in Northern Michigan four-season vacationland. Excellent schools and quality of life. Live on Lake Huron or one of our large inland lakes and be only minutes from the Hospital. Financial arrangements open to discussion. Send c.v. to D. Spedding, Community Memorial Hospital, Box 419, Cheboygan, MI 49721.

FAMILY PHYSICIAN: IMMEDIATE OPENING for a residency trained FP preferring small-town life style and interested in "whole person medicine from the Christian perspective" in a new office in the small college town of Hillsdale in southern Michigan. Write or call: Frederick L. Bean, MD, Hillsdale Family Practice, 111 South Howell, Hillsdale, 49242, (517) 437-7307.

UROLOGIST NEEDED — to join extremely active one-man practice in the four-season vacationland of Northern Lower Michigan. Associate is necessary to share existing workload and to adequately cover our expanded service area. Salary guarantee and fringe benefit package available. If interested, send c.v. to David Spedding, Assistant VP, Community Memorial Hospital, Cheboygan, MI 49721.

SOUTHERN CALIFORNIA — We are seeking experienced specialists and general practitioners for our facilities in Los Angeles and Orange Counties. Located in close proximity to major teaching centers, we offer the opportunity of continued professional development and rewarding clinical practice in association with 350 full time physicians. Compensation and benefits are excellent including paid vacation, educational leave, sick leave, and retirement; insurances included are malpractice, life, disability, medical and dental. Send CV to: Director/Physician Recruitment, CIGNA Healthplans of California, 700 N. Brand Blvd., Suite 500-M, Glendale, CA 91203.

FAMILY PHYSICIANS: Needed to locate in and provide medical care at satellite clinic in three northern Michigan resort communities within our service area. Salary guarantee, vacation, educational leave and fringes provided. Coverage assured and no initial investment required. Call or send current c.v. to: David H. Spedding, Community Memorial Hospital, Box 419, Cheboygan, MI 49721 (616) 627-1201.

Position Wanted

PATHOLOGIST, Certified Anatomic and Clinical Pathology, experienced in both and as Lab Director (Large/small hospitals, commercial labs) seeks full/part-time opportunities for professional or administrative skills in health related field. Box 54, Michigan State Medical Society, 120 W. Saginaw, E. Lansing, MI 48823.

Miscellaneous

ACTIVE GENERAL PRACTICE FOR SALE in Detroit. Doctor relocating out of country. Sale price $24,200. Call Commonwealth Group 288-0022.

ACTIVE MEDICAL PRACTICE FOR SALE. Detroit Area. Grossing $300,000. Call Commonwealth Group 288-0022.

PRACTICES WANTED. We have qualified purchasers looking to assume established M.D., D.O. and D.D.S. practices in Metro area. All inquiries are confidential. Call Commonwealth Group 288-0022.

HEALTH FORCES SALE OF ACTIVE FAMILY PRACTICE in Detroit. Call Commonwealth Group 288-0022.

ESTABLISHED FAMILY PRACTICE FOR SALE in Frankfort, Michigan. Doctor retiring. Call Commonwealth Group 288-0022.

WE HAVE QUALIFIED PURCHASERS looking to purchase Nursing Homes in Michigan. All inquiries are confidential. Call Commonwealth Group 288-0022.

HEALTH CLUB FOR SALE — 11,000 sq. ft. free standing building — all new exercise equipment — Whirlpool, Sauna, Showers. Call (313) 652-1964.

DIABETIC EMERGENCIES. Excellent teaching or review series on the latest handling and treatment of Diabetic emergencies. Suitable for patient teaching. Also, teaching or review for your

office personnel. Runs on Apple II+ or IIE. Self-paced format allows for truly individualized instruction. Complete series: $50.00. Quantum, 106 E. Washington, Coleman, Michigan 48618.

1984 CME CRUISE/CONFERENCES ON LEGAL-MEDICAL ISSUES — Caribbean, Mexican, Hawaiian, Alaskan, Mediterranean. 7-14 days in Winter, Spring, Summer. Approved for 18-24 CME Cat. 1 credits (AMA/PRA). Distinguished professors. FLY ROUNDTRIP FREE ON CARIBBEAN, MEXICAN & ALASKAN CRUISES. Excellent group fares on finest ships. Registration limited. Pre-scheduled in compliance with present IRS requirements. Information: International Conferences, 189 Lodge Ave., Huntington Station, N.Y. 11746. (516) 549-0869.

DOCTOR, YOU CAN'T BEAT THE QUALITY OR THE PRICE! Holter Monitor scanning service. Physician owned, trained and supervised. $35.00 for cassette reports; $45.00 for reel to reel reports; no contracts to sign. We can arrange for lease/purchase of holter equipment. Why are you paying more and getting less? DCG Interpretation (313) 879-8860.

ATTENTION DOCTORS: We have previously owned medical, laboratory, office and x-ray equipment in excellent condition. We buy, sell, trade, move and repair. Office appraisals available by certified surgical consultants. Call Doctor Medical Resale at 313-569-4407, 9 am-9 pm.

LEASE MEDICAL EQUIPMENT — You select. $2,000 to $100,000. Why tie up cash or credit? Call for quote. Medical Leasing Co. 313-879-8860.

PHYSICIANS SIGNATURE LOANS TO $50,000. Up to 7 years to repay. No repayment penalties. Prompt, courteous service. Competitive fixed rate, with no points, fees or charges of any kind. Physicians Service Association, Atlanta, GA. Toll-free (800) 241-6905.

Thanks to our advertisers

AIDS	137
AMRC	135
BCBS/M	145
Brown Pharmaceutical	125
Burroughs Wellcome	139
Campbell Labs	151
Computer Methods Corporation	128
Diversified Business Systems	124
Eli Lilly	129
Kaplan, Stanley H.	144
Lab of Clinical Medicine	154
MDPAC	153
MPMLC	126-127
MSMS Sports Medicine Conference	IFC
Medical Data Service	141
Medical Protective	153
Naples Research & Counseling Center	147
PICOM	131
Pfizer	148-149
Phoenix Baptist	154
Reed Office Systems	146
Roche	IBC
Roerig	120-122
SSTAF	148
Stratton-Cheeseman	155
Upjohn	150

CATEGORY I/Continued

Date: May 5-9, Advanced Muscle Energy Tutorial (below diaphragm). Location: Kellogg Center for Continuing Education, East Lansing. **Sponsors:** Michigan State University College of Osteopathic Medicine and College of Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

Date: May 10, Spring Clinical Conference on Gastroenterology. Location: Gilmore Health Education Center, Bronson Methodist Hospital, 252 E. Lovell, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Education Center. **Cost:** In advance: $60.00; At the door: $70. **Contact:** Charles L. Zeller, MD, Director, Continuing Medical Education, SMAHEC, 1521 Gull Road, Kalamazoo 49001, (616) 388-7881. **Approved for:** 6 hours of Category I Credit.

Date: May 11, Regional Associates Meeting, American College of Physicians. Location: Sheraton Oaks Hotel, Novi. **Sponsor:** American College of Physicians. **Contact:** Arnold R. Axelrod, FACP, Sinai Hospital, 6767 W. Outer Drive, Detroit 48235. **Approved for:** 4 hours of Category I Credit.

Date: May 14-18, Advances in Internal Medicine. Location: Towsley Center, Ann Arbor. **Sponsor:** Office of CME, U-M Medical School. **Contact:** Office of CME, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 34 hours of Category I Credit.

Date: May 17, Perinatal Horizons. Location: Western Michigan University, Kalamazoo. **Sponsor:** Southwestern Michigan Perinatal Association. **Contact:** Marilyn Potgiesser, RN, Educational Services Instructor, Bronson Methodist Hospital, 252 East Lovell Street, Kalamazoo 49007 (616) 383-6405. **Approved for:** 6 hours of Category I Credit.

Date: May 18-19, 27th Annual Clinic Days: Transfusion and Infusion Therapy in Pediatrics — Current Concepts. Location: Children's Hospital of Michigan, Detroit. **Sponsor:** CME Department, Children's Hospital of Michigan. **Contact:** CME Department, Children's Hospital of Michigan, 3901 Beaubien Blvd., Detroit 48201 (313) 494-5455. **Approved for:** 10 hours of Category I Credit.

Date: June 11-15, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsors:** MSU Colleges of Osteopathic Medicine and Human Medicine, and the North American Academy of Manipulative Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

Date: June 13, Update on Geriatrics — 1984. Location: St. John Hospital, Detroit. **Sponsor:** Family Medical Center, Detroit. **Contact:** Judy Danbert (313) 343-3877. **Approved for:** 7 hours of Category I Credit.

Date: June 24-29, 20th Annual Northern Michigan Summer Conference: An Update on Common Clinical Concerns. Location: Hilton Shanty Creek, Bellaire. **Sponsor:** U-M Office of Continuing Medical Education. **Contact:** Office of CME, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 20 hours of Category I Credit.

Date: July 26-27, Coller Penberthy Thirlby Medical Conference. Location: Park Place Hotel, Traverse City. **Sponsor:** Munson Medical Center. **For:** All interested physicians. **Contact:** Norma Powers, Coordinator of Medical Education, Munson Medical Center, 6th and Madison Streets, Traverse City 49684 (616) 922-9544. **Approved for:** 9 hours of Category I Credit.

Date: August 13-17, Tutorial on Direction Action Thrust Manipulative Therapy. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU College of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

Date: September 8-12, Fundamental of Muscle Energy. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU College of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517). 353-9714. **Approved for:** 40 hours of Category I Credit.

Date: September 10-12, Hemodynamic Monitoring. Location: Towsley Center, Ann Arbor. **Sponsor:** U-M Dept. of Pathology and Office of Continuing Medical Education. **Contact:** Office of CME, Towsley Center, Box 057, U-M Medical School, Ann Arbor, 48109, (313) 763-1400. **Approved for:** 14.5 hours of Category I Credit.

Date: September 21-23, Tutorial on Myofascial Release Technique. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 24 hours of Category I Credit.

Date: October 6-10, Advanced Muscle Energy Tutorial (Above Diaphragm). Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

Reflections of the board chairman

When President Crandall asked me to be the guest writer for the President's Page, I was both delighted and honored. I thought this would be an opportunity to let you know how your medical society and its board of directors (Council) functions.

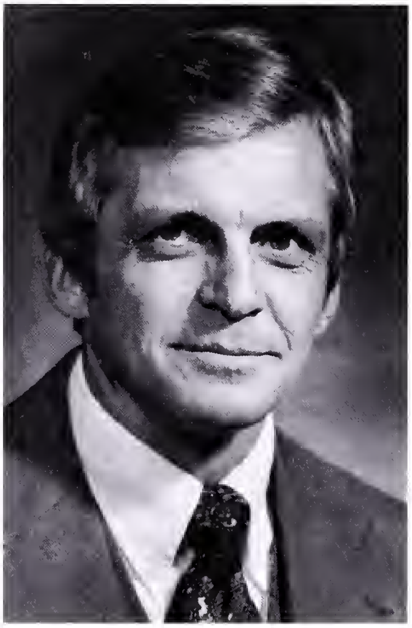
Until last May's House of Delegates we were always The Council. Because in all correspondence and communications with outside groups, it had to be explained that we were actually the board of directors, the House of Delegates decided a name change was timely. The name change will become official this May with the second reading. I will use board of directors rather than council from here on.

Much more

The duties described by the constitution for the board are that it is the executive body of the society and the control of the finances of the society. In reality it does much more. I paraphrase what actually happens by saying that the House of Delegates meets once each year to make policy and the Board meets throughout the year to implement that policy.

The Board is composed of directors (councilors) elected from districts throughout the state. They are nominated by the delegates from each district and elected by the House of Delegates.

Immediately after the annual meeting of the House, the board (with all newly-elected directors) meets to organize. The two officers elected are the chairman and the vice chairman. Also elected are the chairmen of the board's reference committees — Finance, Health Care Delivery, Legislative Policy and Scientific and Educational Affairs.


Thomas R. Berglund, MD
Chairman, MSMS Board
of Directors

During the year the board meets every six to eight weeks. Reference committees convene at 10 a.m. on the appointed days to discuss those reports of MSMS committees and other issues referred to them. Following due deliberation, each chairman prepares a report for the full board.

Each luncheon is followed by a discussion of some concern of the board. These are issues which your board needs to be informed of but which do not necessarily fit into the agenda. During the past we have discussed surgicenters, arbitration and GMENAC. We also have heard reports from the medical school deans; Elizabeth Howe, director, Department of Licensing and Regulation, and the director of the state budget.

Daily contact

Following the luncheon, the full board meets until the agenda has been completed. Between board meetings the chairman is in almost daily contact with MSMS staff and officers to maintain orderly conduct of the business of the society.

Much of the work of the society is done by committees of the society which are appointed by the board. These committees range from Medical Education to State Legislation to Public Health and many more. If you have an interest or expertise and would like to volunteer to work for MSMS, contact your director or write me at MSMS.

Finally, this is an election year. Lobbying on your behalf at both the federal and state levels is one of the most important MSMS functions. You can volunteer to come to Lansing for a day to lobby. If you cannot come in person then send your *personal* check for $150 to MDPAC, addressed to me at MSMS so we can elect friends of medicine.

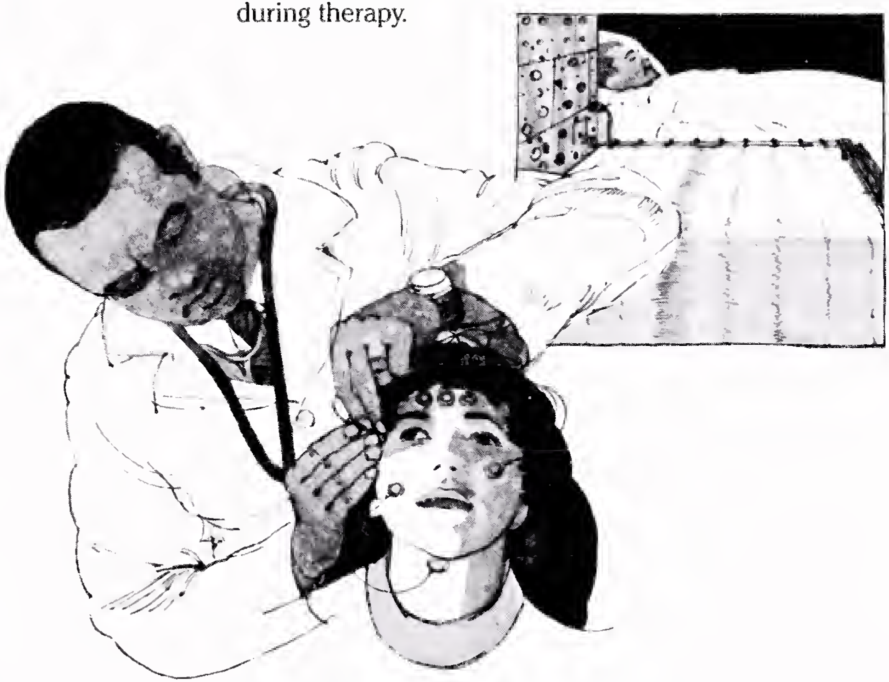
The weight of objective evidence supports the clinical efficacy of

Dalmane® Ⓒ

flurazepam HCl/Roche

15-mg/30-mg capsules

- Studied extensively in the sleep laboratory—the most valid environment for measuring hypnotic efficacy.[1-12]
- Studied in over 200 clinical trials involving over 10,000 patients.[13]
- During long-term therapy, which is seldom required, periodic blood, kidney and liver function tests should be performed.
- Contraindicated in patients who are pregnant or hypersensitive to flurazepam.
- Caution patients about drinking alcohol, driving or operating hazardous machinery during therapy.



References: 1. Kales A *et al: J Clin Pharmacol 17*:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. **2.** Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **3.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **4.** Kales A *et al: JAMA 241*:1692-1695, Apr 20, 1979. **5.** Kales A, Scharf MB, Kales JD: *Science 201*:1039-1041, Sep 15, 1978. **6.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **7.** Kales A, Kales JD: *Pharmacol Physicians 4*:1-6, Sep 1970. **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **9.** Dement WC *et al: Behav Med 5*:25-31, Oct 1978. **10.** Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **11.** Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. **12.** Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. **13.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

Dalmane® Ⓒ
(flurazepam HCl/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

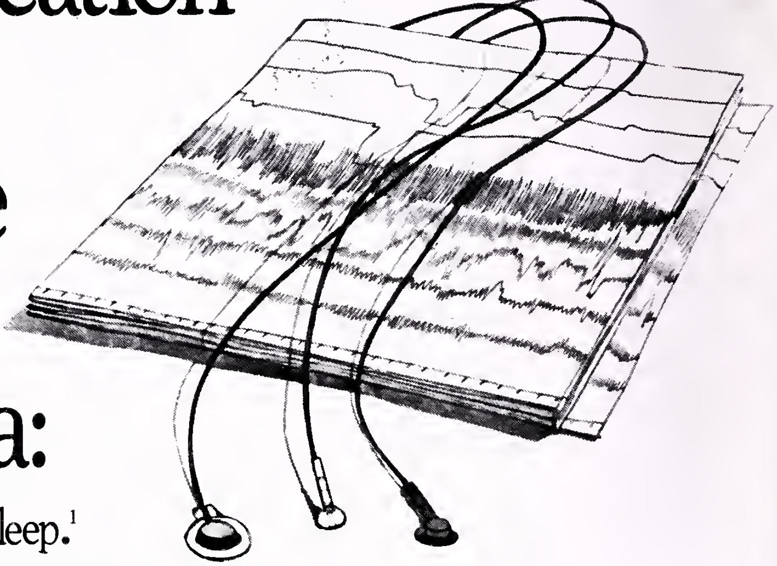
ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

225 00000000000 123184
SERIALS DEPT - LIBRARY
COLLEGE OF PHYS OF PHILA
19 SOUTH 22ND STREET
PHILADELPHIA, PA 19103

Contemporary Hypnotic Therapy

Dalmane® {flurazepam HCl/Roche} Stands Apart

Only one sleep medication objectively fulfills all these important criteria:



- ·Rapid onset of sleep.[1]
- ·More total sleep time on the first 3 nights of therapy.[1]
- ·More total sleep time on nights 12 to 14 of therapy.[1]
- ·Continued efficacy for at least 28 nights.[2]
- ·Seldom produces morning hangover.[3]
- ·Avoids rebound insomnia when therapy is discontinued.[1,4,5]

15-mg/30-mg capsules

Dalmane® Ⓘⓥ
flurazepam HCl/Roche

ROCHE
Roche Products Inc.
Manati, Puerto Rico 00701

Copyright © 1984 by Roche Products Inc. All rights reserved.
Please see summary of product information on reverse side.

MICHIGAN MEDICINE

April 1984 JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Volume 83, Number 19

RESEARCH
HMO
CONTRACT
PPO
SERVICE
CARE
NEEDS

MARKETING THE MEDICAL PRACTICE

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA
APR 23 1984

Whom to call at MSMS headquarters

MSMS address:

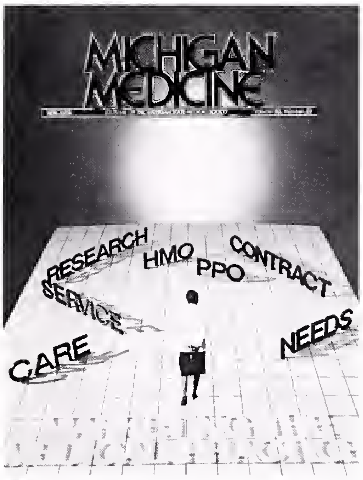
Michigan State Medical Society
120 West Saginaw (Box 950)
East Lansing, MI 48823

MSMS telephone:
517/337-1351

Address changes	Peg Berry
Advertising (in *Michigan Medicine*)	Joyce Crum
AMA Delegation	Bruce Ambrose, Wayne Burmeister
Annual Scientific Meeting Program	Sherry Fent
Arbitration	William Madigan
Auto Lease Plan	Wayne Burmeister
Blue Cross Blue Shield/Third Party Payors	John Richards
Board of Medicine	Sherry Wellman
Continuing Medical Education	
Accreditation	Vada Davis
Category I Calendar (for *Michigan Medicine*)	Joyce Crum
MSMS-Sponsored Conferences	Sherry Fent
Dues Billing & Payments	Peg Berry
Financial Operations	Dick Campau
GTE/MINET	Ellen Vinocur Potash
HMOs/PPOs	John Richards
Impaired Physicians	Katie Brewbaker
Jail Health Project	Dick Campau
Judicial Commission	Vada Davis
Legislation	Bruce Ambrose, Kevin Kelly
Maternal Health Committee and Conference	Katie Brewbaker
Medicaid	Sherry Wellman
Medical Assistants	Caroline Rich
Medical Care Costs	John Richards
Medical Ethics	Vada Davis
Medicare	Debbie Zannoth
Medigram	Judy Marr
Medi-Lease	John Anthony
Meeting Information (National, State)	Joyce Crum
Member Services (including insurance programs)	Wayne Burmeister
Membership Records	Peg Berry
Michigan Association for Medical Education	Vi Heins
Michigan Doctors Political Action Committee	Kevin Kelly
Michigan Chapter, American College of Surgeons	Vi Heins
Michigan Medicine (MSMS Journal)	Judy Marr
Michigan Society of Anesthesiologists	Caroline Rich
Michigan Society of General Surgeons	Caroline Rich
Michigan Society of Respiratory Therapists	Caroline Rich
MSMS Auxiliary	Caroline Rich
MSMS Committee Meeting Schedule	Katie Brewbaker
MSMS House of Delegates Agenda and Schedule	Dick Campau
MSMS Meeting Facilities	Linda Munson
MSMS Travel Programs	Donna Farougi
Patient Information, MSMS PR Materials	Barb Prevo
Physician Hospital Relations	William Madigan
Physician Legislative Network	Kevin Kelly
Physician Service Group	John Anthony
Practice Management	John Anthony
Professional Liability Insurance	William Madigan
Public Health	Sherry Wellman
Specialty Societies	
Information	Nancy Wimmer
Committee of Specialty Society Presidents	William Madigan

April 1984, Vol. 83, No. 19

MICHIGAN MEDICINE



About the cover:

The need for marketing the physician's medical practice is the subject of this month's cover and special report. (Photo by Kim Kauffman, design by Martin Hudson)

***Michigan Medicine* took top prize for state medical society publications of 3,000 and more circulation in the 1984 Sandoz Medical Journalism Awards competition.**

The MSMS monthly was chosen for outstanding appearance and editorial qualities. The Sandoz awards recognize the unique importance of state and local professional journals and are part of a year-round project to stimulate and develop improved journalism techniques among small-circulation, specialized health publications.

The award is the fifth earned by *Michigan Medicine* in six years of entering the competition. The magazine also won first place in 1978, and since has garnered two honorable mentions and a special award.

A prize of $500 and a commemorative plaque will be presented by Sandoz at the 1984 MSMS House of Delegates Meeting.

SPECIAL REPORT

162 Marketing is not advertising — it's a dignified process involving research, data analysis and careful managerial skills. In the physician's practice its goal is to ascertain the needs of patients and to organize medical services to meet those needs. That is the message of this month's special report. In these pages, *Michigan Medicine* offers a discussion of how and why physicians need to learn marketing skills; provides some practical marketing tips straight from the MSMS booklet, *Challenge of the 80s: A guide to successful medical practice;* and describes continuing MSMS efforts to teach marketing nuts and bolts to members; J.C. Rosenberg, MD, MBA, and Richard H. Gascoigne, MD

FEATURES

173 It is MSMS policy . . . New series on official MSMS policies provides stand on care of the handicapped, including "Baby Doe" cases

184 Former state public health department director Maurice S. Reizen, MD, taking on new career; Millicent Lane

191 Complete statistical report on Michigan's FMGs, and women physicians; Mert Scholten

196 Legislative Profile: Senate Majority Leader John Engler; Carole Eberly

200 PROM intent on securing Michigan PRO contract; Deborah Zannoth

DEPARTMENTS

160 In my opinion; Leland E. Holly, II
161 Letters
176 New members
206 MSMS/A; Dorothy Csonka
208 News; Joyce Crum
210 Medical newsfronts
212 Meetings
213 Board of Medicine actions
214 Category I courses
216 Deaths
217 Classified ads
218 Ad index
220 President's page; Donald K. Crandall, MD

"The golden rule"

By Leland E. Holly II, MD

We all know the Golden Rule: "He who has the gold, rules." This appears to be verified as we move into DRGs, PPOs, "cost caps," and witness hospital and physician behavior in response to them. I am personally concerned with my own "positioning" to survive their implementation. You should be, too.

I subscribe to the recent extension of the Golden Rule which is "He who has good information and data controls the gold and the rules." I need to know more about my practice — its costs, my patient sources, its strong points and weaknesses. I need to know what my patients really expect of me (not what *I* think they expect). I want to know whether I meet my patients' and referring doctors' expectations. I want to know who pays me, how much and to whom I give discounts. I want to know when my practice philosophy costs money or reduces productivity. I want to know what is really happening in my front office.

I want to know what my hospital practice means to me and whether it needs increasing, or whether I want to practice there as much as I do.

I need to know how much my style of practice costs the patient and whether I could be smarter and have it cost them less for the same quality.

I want to know some national, state and local statistical norms to compare myself to.

I need to know a host of facts to make some big decisions intelligently about my behavior (habits) and my practice in order to position myself to obtain an equitable share of the medical dollar. The person (or hospital) that knows more will make better decisions and get a bigger share than I do. The payor that knows more will out-smart me every time.

You need to know all these facts, too, about your own practices and for the same reasons.

If we can't rule we can at least obtain a draw. We have three information sources to turn to — our practices, our friendly hospitals (not the unfriendly ones) and our Michigan State Medical Society. The sooner, the better.

Don't waste any time; ask for help.

Doctor Holly is MSMS treasurer, and a member of the MSMS Committee on Publications. He also is president of the MSMS/PSG. For more on "positioning," see this month's special report, beginning on page 162.

Michigan State Medical Society
Warren F. Tryloff, director

Committee on Publications
Busharat Ahmad, MD, Marquette, chairman
Harvey Andre, MD, Grand Rapids
Vickers C. Hansen, MD, Manistee
Leland E. Holly II, MD, Muskegon
James H. Tisdel, MD, Port Huron

Editor
Judith Marr

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

MICHIGAN MEDICINE (ISSN 0026-2293) is the official journal of the Michigan State Medical Society, published under the direction of the Publications Committee. Published five times a month, 60 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $30.00; single copies, $1.50. Additional postage: Canada, $1 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to articles, news, exchanges, should be addressed to Judith Marr, advertising inquiries to Joyce Crum and address changes to Peg Berry, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517-337-1351.
©1984 Michigan State Medical Society

Michigan Medicine redesign

I like your new typefaces, margins and headlines. I especially like your Madonna on the cover (January, 1984). This is simply terrific, keep up the good work.

Frederick J. Cady, Jr., MD
President
Saginaw County Medical Society

Your redesign is wonderful! I like the typeface very much, and I consider it a very clean, crisp design.

The table of contents page is very attractive as well as informative. I also like your use of *big* pictures in the journal. So many medical journals use only 19 pica pieces of art.

Mariann Stephens, the managing editor of the *Illinois Medical Journal,* which will publish its first redesigned issue this month, told me about your new look. She is in love with Friz Quadrata. Me thinks we editors have peculiar loves, no?

John J. Bausch, Editor
Chicago Medicine

Michigan Parkinson group

The Michigan Parkinson Foundation has been formed. Its purpose is to provide education and support to Parkinson patients and families through:

1) Educational workshops for small groups held once weekly for six weeks;

2) Formation of support groups in Michigan cities. Eight such support groups are currently functioning in the Detroit Metropolitan area;

3) Open lectures by local and national speakers four or five times yearly;

4) Regular publication of a newsletter, "The Michigan Parkinsonian;"

5) Cooperation of patients and physicians to support clinical research; and

6) Education, through seminars and manuals, of all health professionals in order to provide better care to patients with Parkinson's.

Further information can be obtained, and physicians and patients can be placed on the mailing list, by contacting *Michigan Parkinson Foundation,* 3990 John R., Detroit, 48201, (313) 494-8916.

Raymond B. Bauer, MD
President, MPF
Detroit

AMA membership grows

The following letter was received recently at MSMS headquarters.

I am pleased to announce that the Michigan State Medical Society has increased AMA membership in Michigan for 1983. This is the sixth consecutive year that your society has surpassed its previous year record of AMA members. The attention paid to membership by you and your staff has certainly been worthwhile and I thank you for your efforts.

In the past, the criterion for recognizing membership activity has always been the increase in dues-paying members over the prior year. However, because of the 1983 change in AMA's dues exemption policy, which allowed more dues-paying members to become exempt members, this year's comparison is based on total membership. Next year the comparison will again be based on dues-paying members.

Doctor Crandall, please accept my thanks and appreciation for your membership efforts on behalf of the American Medical Association.

Frank J. Jirka, Jr., MD
President
American Medical Association

Social impact

I have just received the *Child Abuse* issue of *Michigan Medicine* (February, 1984).

MSMS should be congratulated on doing such an excellent job with a difficult and sensitive subject. I feel that each author explored their topic in detail, but the format kept the reader intrigued.

I must take issue with the cover design. I do not think it reflects adequately the extent of the problem. All of the children pictured appear to be from one racial or ethnic group. I realize that MSMS is a majority organization, but child abuse has no limitations.

Take a second look at the cover and I am sure that you will have a different concept. From the artistic point, it is extremely well done, but I feel that it lacks social impact.

Natalia M. Tanner, MD
Chairperson, Michigan Chapter
American Academy of Pediatrics

MOVING?

***Michigan Medicine* wants to know**

Please notify us a week or two in advance.

CHANGE MY MAILING ADDRESS TO:

Name

Address

City State Zip

Please paste old mailing label here:

Please send to: Peg Berry, MSMS, P.O. Box 950, East Lansing, MI 48823.

By J.C. Rosenberg, MD, MBA

Application of marketing to medical practice

RESEARCH
HMO
CONTRACT
PPO
SERVICE
CARE
NEEDS

Marketing is misunderstood by those outside the ranks of management more than is any other aspect of managerial activity.

It is erroneously equated with advertising and selling. The latter are important aspects of the marketing process but by no means the essence of it. This gap in our knowledge about marketing is a major impediment to realizing the many benefits which can accrue from the application of marketing principles to medical practice.

The major purpose of this presentation is to explain what marketing is and to show how it successfully can be used to benefit physicians, patients and organizations responsible for the costs of health care.

Defining marketing

Marketing is best understood by reviewing its origins. Not too long after the establishment of large manufacturing concerns in the latter half of the 19th century, it became obvious to the leaders of some companies that the products of their factories were not selling as well as they had when they were first introduced.

Several possibilities were presented to explain the decreased interest in their products. The marketplace may have become saturated with the product. The firm's success may have attracted competitors who in turn produced a better product and took

---

Doctor Rosenberg is professor of surgery at Wayne State University and chief of surgery at Hutzel Hospital in the Detroit Medical Center. He has an MBA degree from Michigan State University and has been called upon by MSMS to lecture and consult on how one can apply management sciences techniques to the delivery of health care.

away some of their customers.

The heads of these manufacturing plants felt the need to find out precisely what was responsible for the changes which were taking place. They also wanted to know what they could do to adapt to the changing times and maintain the viability of their organizations. They charged a group of their brightest executives to look into the problem, to find out what the public wanted which their factories could produce.

This was the function which became "marketing." It has a very scientific factual orientation known as marketing research. The acquisition of data about the company, its capabilities and capacity and how it can supply the needs and desires of a group of customers — its "market" — was, and is, a vital function of marketing. It enables organizations to adapt to changing times — changes brought about by technology, competition or new directions in tastes or needs of society.

This scientific aspect of marketing has to be coupled with an imaginative, creative interpretation and use of the data derived from marketing research. Defining what your organization can do and what is needed or desired in the marketplace have to be brought together in the form of a marketing plan, a program whereby the organization provides the products or services which are desired or required by society. It is only then that one uses promotional and selling techniques to make it known that you can supply the needs which your research has perceived to exist.

Medical practice

The news abounds with evidence that major changes are taking place in health care. Until recently, physicians were the main components of this activity. A physician who completed his or her training and acquired a license would have no difficulty building a practice in a short period of time. The demand for our services was high and the supply of physicians was limited. Medical care could be provided at reasonable costs and there were few alternatives to what the physician in private practice had to offer. This may have been true in the decades after the last world war. It is not true in the 1980s.

Today, concerns over costs are universal. As a major component of the health care delivery system, physicians in practice are being pressured to decrease those costs. Pre-payment plans are proliferating and competition for patients is increasing. There no longer is a physician shortage, and medical specialties are crowded with well-trained physicians whose skills are not widely required. Large group practices are becoming more popular and more physicians are becoming employees of these groups, as well as working for hospitals. Physicians' incomes are decreasing. Physician involvement in decision making also is decreasing as public officials and representatives of industry and labor determine health care policy.

Marketing management

The physician in practice today is much like the industrial innovator who could not understand what was happening to the popularity of his product. The answer was found, to a great extent, in the marketing philosophy. We physicians can use the same approach. We must think of ourselves as part of a service industry — the health care industry. Our treatment of the sick is our product. We must begin to look at how we can develop better ways of delivering this service, pricing it to make it attractive and distributing and promoting it so that its benefits are widely known and available.

The physician in practice today should identify the patients, referring physicians and/or organizations such as hospitals, PPOs and HMOs which are his or her market. A careful assessment of the needs and desires of this group should follow and a plan should be devised to fill those needs.

This approach is consonant with the highest ideals of the medical profession. It is not demeaning nor does it commercialize our profession. It uses a scientifically-oriented approach to acquiring data and puts the information to use in serving those who are the recipients of our services and skills.

Our market is our patients, referring physicians and the hospitals and organizations which underwrite the costs of the care we render. It is our obligation to use all possible means to serve them as best we can.

By Richard H. Gascoigne, MD

MSMS "Challenge of the 80s" helps physicians adapt

MSMS members Thomas Higby, MD (left) and Clyde Flory, MD (center) are joined by Helen Higby in attending an early "Challenge of the 80s" conference.

No one argues that medicine is changing. Debate centers over whether the changes are for better or worse, in what direction and whether physicians' or patients' lives will be needlessly compromised by the inevitable course of change.

The role of a professional association at this juncture is to assist its members to recognize the changes and position themselves to emerge the better for them.

To that end the Michigan State Medical Society last year developed the book, *Challenge of the 80s: A guide to successful medical practice*. This resource contains hundreds of ideas to help the physician achieve maximum practice efficiency while building a practice in ethical fashion and without sacrificing quality of care.

MSMS book

The book began as a series of *Michigan Medicine* articles developed by the MSMS Committee on Public Service. The articles subsequently were gathered in the printed edition of the 134-page paperbacked book, which is available to members for $5 and to non-members for $12.50.

The committee expanded its efforts, working with MSMS staff and consultants to develop a one-day seminar for physicians. This seminar covered practice efficiency, personnel matters, computers, business matters, and patient communications. It also offered a two-hour session on marketing principles and their use in medical practice. The seminar was offered 10 times at convenient locations across Michigan from Kalamazoo to Saginaw and from Detroit to Marquette.

Well over 400 MSMS members and their office staffs attended these seminars, which were designed to augment and supplement the content of the book.

New seminars

Acting on the evaluations of these seminars and with the advice of MSMS consultants and staff, MSMS is planning an additional series of programs to help physicians recognize and meet the continuing dynamic changes confronting medicine.

These seminars will be of two types.

MSMS will conduct more seminars for physicians which will build upon last year's meetings. (Watch *Medigram* and direct mailings for exact dates and locations.) And if demand is sufficient, the offering will be repeated in the fall.

Topics will include making business decisions, computers in medical practice, personnel matters, managing patient flow, marketing decisions, and practice alternatives (a look at PPOs, HMOs and contracting).

The second program will be a seminar for medical assistants. This will be a half-day morning conference. Topics to be covered include patient flow, appointment scheduling, financial management and controls, collection techniques and patient/office communications. The registration fee will include all handouts, as well as coffee and refreshments. Watch *Medigram* for complete list of sites, dates and fees for this program.

Doctor Gascoigne, an Adrian general surgeon, is chairman of the MSMS Committee on Public Service.

Marketing helps physician meet patients' needs

The following article is taken from the section, "Analyzing Market Potential," of the book, *Challenge of the 80s: A guide to successful medical practice*, published by MSMS in 1983. Copies of the book, with its four chapters on competition, communication, practice management, and medical ethics, are available for $5 each by writing Mert Scholten at MSMS, 120 W. Saginaw St., East Lansing, 48823.

Medical marketing has some specific characteristics that must be understood and kept in mind. First, the use of medical services is not possible without the participation of the physician and the capacity to deliver the service must exist before any transaction can occur. Second, since the service is produced and consumed simultaneously with payment being made later, the good faith of the consumer is critical.

Because of these factors, combined with the intangible nature of most medical services, the potential customer (patient) must understand both the nature and the benefit of the service before it can be sold. These may seem to be quite obvious statements, yet one of the most common complaints from patients is that the physician does not take time to explain the need for nor the effects of a particular course of treatment. Not surprisingly, this failure is often the basis for malpractice suits and is one of the first aspects of a medical practice that risk management consultants investigate.

The basic concept for physicians to keep in mind when preparing a marketing plan is that it requires two-way communication. Theodore Levitt, in his book *The Marketing Mode*, provides the following comparison of marketing and selling: "Selling tries to get the customer to want what the company has. Marketing tries to get the company to have what the customer wants."

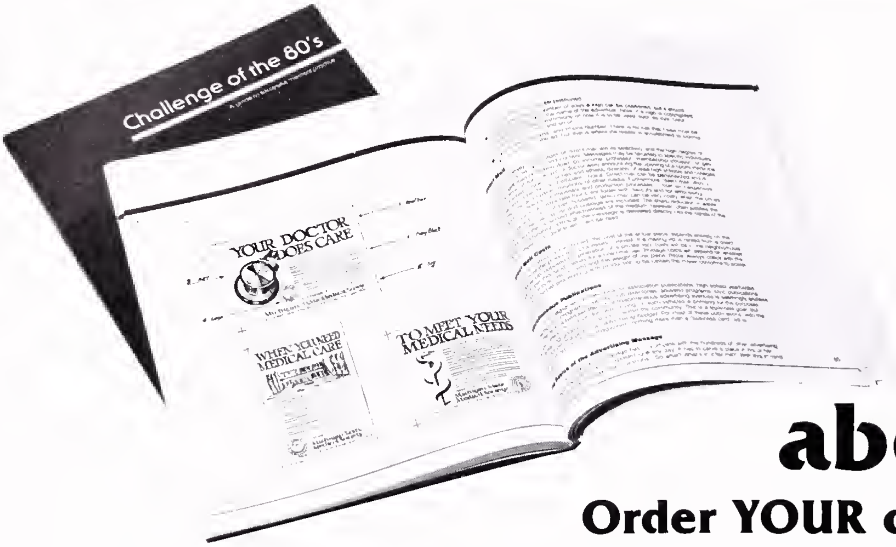
Finding what the customer wants is a function of market analysis. This task is one that can be done by an individual practitioner using fairly simple information-gathering techniques, or it can be given in-depth treatment by specialists using highly sophisticated research methods. The choice will largely depend on the size of the practice and the amount of time and money the physician is willing to invest.

"Finding what the customer (patient) wants is a function of market analysis."

Regardless of the plan's sophistication, there are some basic elements that any marketing scheme should include:

- **Written mission statement.** This statement should include an objective look at where the practice is, in terms of its operations, patient base and competition, and where it plans to be at the completion of the marketing plan. This means that the statement must be specific in terms of its goals and the time frame in which the goals are to be met.
- **Description of practice.** What clinical procedures are performed and which are done most frequently? Who are the practitioners involved (including paramedical staff) and what are their backgrounds? What facilities does the practice have, during what periods are they utilized, and are they up-to-date? With which hospitals and/or clinics does the practice have working relationships? What is the primary service area based on a patient origin study? What percentage of the potential patients in the area are served by the practice?
- **Description of service area.** The physician should contact local chambers of commerce and business development groups for information. How many persons and households are there in the service area? What are the ages, income, education and percentage of two wage-earner families? Who are major employers and what are their prospects for the future? What are the mobility factors of persons in the area and how does the turnover rate compare with the practice turnover? What are the five- and ten-year

Continued on page 168



Be wise about the 80's

Order YOUR copy of this book today!

The physician is trained for the practice of medicine by years of formal schooling, internship, and residency. But his knowledge of business management and ethical implications is too often obtained by trial and error of experience.

In the years during which I have been exposed to the legal problems of physicians, I have been impressed by the fact that earlier legal advice or even a small measure of business know-how might have avoided an unfortunate situation.

Consequently the section entitled "Ethical and Legal Considerations" of the MSMS booklet *Challenge of the 80s — A guide to successful medical practice* provides much needed background which should help all physicians recognize common enigmas for which they should seek advice.

Choosing a lawyer, business-related documents including medical records, and responding to lawsuits are by-products of our age of conflict and mistrust. Accuracy in and safekeeping of all records has been emphasized previously but the necessity for confidentiality of medical notes has remained vague in the education of many medical practitioners. It is exhilarating to see a precise two-page statement on this topic in the MSMS guide.

Hospital privileges — access to the doctors' workshop if you will — is an issue which only can be mentioned in the present manual. From the time of Hippocrates, the declared attitude of the profession has always been idealistic, with the assumption that the ideal should be compromised as little as possible. Unfortunately with the advent of regulatory agencies, idealism is almost impossible. The physician must live, and has a debt to his or her family, as well as to society. Therefore rules and customary procedures in day-to-day practice are introduced in the booklet to promote financial success of the practitioner and the dignity of the profession.

It is sad but true that there is a scarcity in libraries and medical education of literature on the subject of ethics. The *Challenge of the 80s* opens the door by emphasizing the mechanics of ethics at both national and state levels.

Challenge of the 80s is a welcome guide to practice — it can be recommended without reservation. A particular, felicitous feature of the section on ethics and law is its tone: kind and considerate — not condescending.

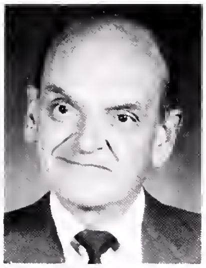
Donald N. Sweeny, Jr., MD, Detroit
MSMS Judicial Commission

All doubting Thomases take note: no more graphic proof of the growth and transformation of American medicine could be found than that in the communications chapter of the MSMS Book "Challenge of the 80s: A guide to successful medical practice."

Fifteen years ago, who would have thought that MSMS would provide instructions to physicians on how to use the media for advertising? This section is practical, even provides cost information and gives enough information to permit the physician to design a simple ad and decide when to run it. This really amounts to an outstanding 16-page primer on the basics of advertising — something virtually no physician is likely to have ever read before.

The communications chapter also concentrates on recommendations for improvements in the more conventional ways of developing a physician's reputation, for those not ready to run an ad in the local newspaper.

The physician is taught how to show his or her interest in and consideration of the patient, how



Doctor Sweeny

Doctor Adelman

Doctor Bryant

office reception areas and personnel may affect the patient's perception of the doctor's care, how to elicit or actually survey patients for feedback on their reactions to their care, how to develop good working relationships with referring doctors, and how to exhibit effective teamwork in the hospital setting.

A surprising number of concrete, specific, and practical suggestions may be found here, many of which will be new to readers.

Times are certainly changing. Those who do not wish to be left behind should read "Challenge of the 80s: A guide to successful medicine practice," if they want to learn how to change along with the times.

Susan J. Adelman, MD, President
Wayne County Medical Society

Practice management, second of the four-part series in the MSMS "Challenge of the 80s" book, takes the reader through a lifetime of medical career planning. It begins with such rudimentary considerations as solo versus group practice, lease-buy options, and incorporation, noting trends and debating various advantages and drawbacks.

Running an efficient work-a-day office is the main theme. Timely sections discuss appointments, fees, billing, collections, purchasing, controls and safeguards, and computers. Employee selection, motivation, management and termination are reviewed at length. The prudent use of consultants and advisors (such as accountants and attorneys) is addressed, as well as relationships with patients, other physicians and hospitals. The importance of formulating and enunciating clear office policies, procedures and positions is emphasized.

Finally, a brief dissertation on investment and retirement goals is appropriately included.

Full of nuts and bolts practicality, this rich, concise text is typical of the quality of the entire volume, *Challenge of the 80s: A guide to successful medical practice.* Well conceived and executed, it is a book to acquire, read and use in your practice.

Frederick W. Bryant, MD
MSMS District Director

Please send me ____ copy(ies) of *Challenge of the 80s: A Guide to Successful Medical Practice.* Enclosed is my check for $____ ($5 x number of copies, or $15 x number of copies if non-member).

Name ____________________

Address ____________________

____

City ____________________ Zip ____________

MSMS, 120 W. Saginaw, East Lansing, MI 48823

projections for growth? Who are the primary holders and purveyors of capital? What is the tax status of the communities? What hospitals and out-patient-clinics serve the area? What news media are there and who are the persons to contact?

- **Current and potential competitors.** A listing of all private practitioners, PAs, HMOs, hospital services and free-standing clinics that offer — or may offer — services similar to those provided by the physician's practice is important. Where possible, identify by name the physicians and key paramedical professionals involved in these services. Are there other services being planned? Where will they be located and how will they operate? Summarize the strengths and weaknesses of each service and estimate the number of patients that they serve. What is the nature and frequency of promotional material produced by competitors? (Prepare a file of printed materials and include tapes of radio and television announcements.) Try to determine or estimate the amount of dollars spent by competitors in promoting their services.
- **Patient profile.** Prepare a listing of the practice's patients that will include the following information:
  - Address, age, sex, marital status, number of children.
  - Employer and occupation (spouse also, if employed)
  - Initial referral source and diagnosis.
  - Insurance or payment source.
  - Educational and income status (if possible).

Once these data are obtained and recorded (preferably in a computer) it will be possible to prepare a composite that can be used to compare the practice against the demographic information for the service area. This comparison can often point up discrepancies and anomalies in the patterns of patient service and referral that characterize the physician's practice. For example, if the demographic data shows that the average age of persons in the service area is 35 and yet the patients in the practice are predominantly in the 50 to 60 bracket, the physician will want to check the referral source of new patients to determine why he/she is not drawing from the primary patient pool. Plotting patients' residences on a map may show pockets of scarcity, which may indicate that persons in that area have, for some reason, a negative image of the practice.

Development of a market data base is particularly important if a physician plans to expand the size of the partnership or PC, open a satellite office, or offer new services. In such cases, he/she will probably want more information than is available from existing sources. This may lead the physician to consider a survey and to make a decision between conducting it in-house or hiring outside help. Generally, this decision is made on the basis of available funds and the size of the project. There is, however, no particular reason why a fact-gathering survey cannot be done internally.

(There follows a detailed plan for a productive market survey.)

" . . . it will be possible to prepare a composite . . . to compare the practice against . . . the service area."

When the market data are assembled from all possible sources, it is time for analysis and the setting of goals. The analyzing of information almost always produces a number of results that merely reinforce positions that have previously been taken. It is useful to have documentation that makes decision-making more comfortable.

The analysis process should ideally represent an ongoing effort. If the information is entered and stored on a computer, it can be updated and retrieved for future study much more easily.

Having determined that the market situation is favorable for pursuing the physician's primary objective, it is necessary to develop an action plan, or hierarchy, for accomplishing the objective. The first step in this process is to clearly and definitively articulate the primary objective. It should then be shared with the office staff, partners, and others who must have a role in attaining the objective.

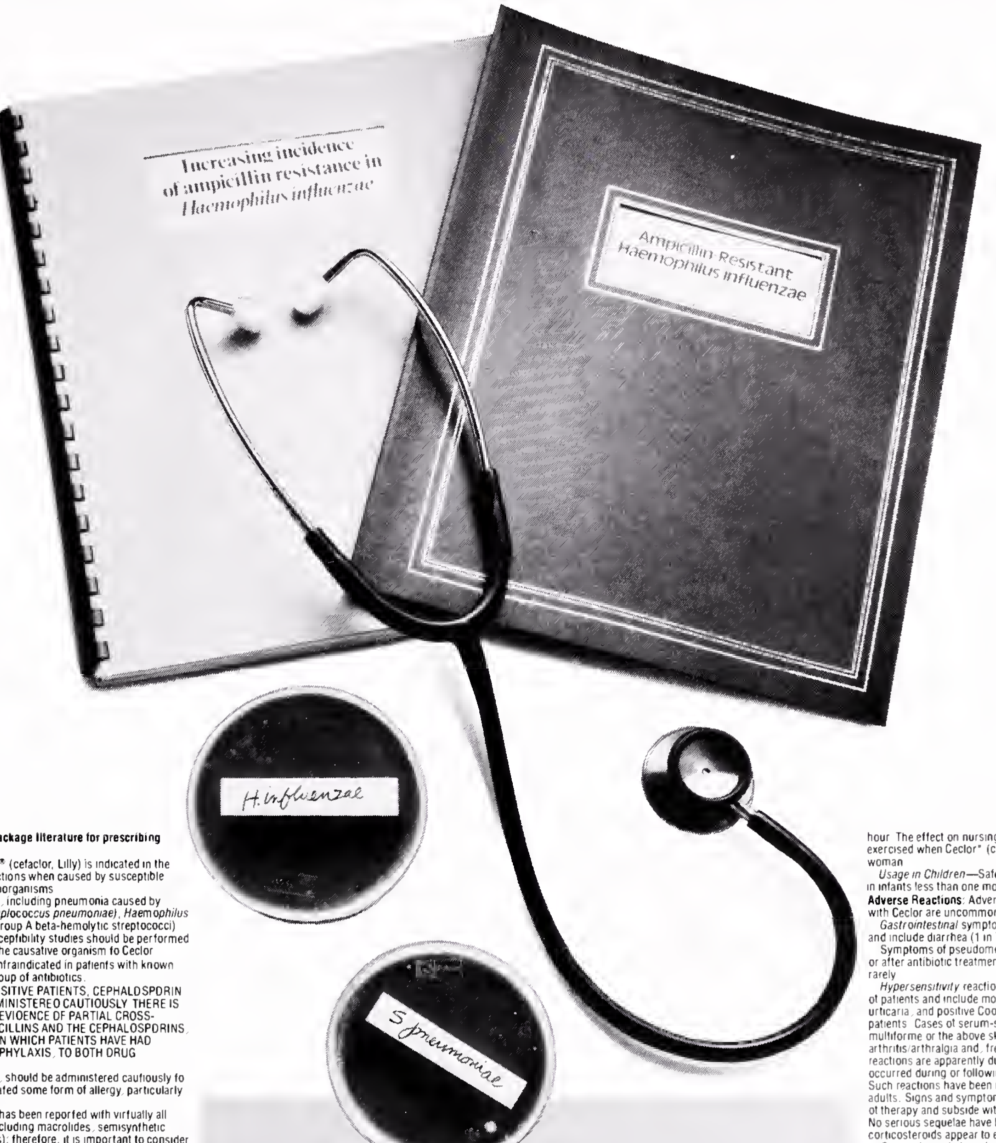
Next, a series of subobjectives should be defined and prioritized with a time-line and responsible person assigned to each. If, for example, it is decided that x-ray services will be offered by the practice, the primary objective might be stated, "The practice will purchase x-ray equipment, hire necessary technologists, and install the system within 120 days."

The list of subobjectives would include such items as:

- Contact x-ray equipment suppliers and arrange for a representative to inspect office site and develop proposal for installation: Dr. Smith (complete by X-10).
- Have building contractor inspect site and develop renovation proposal: Dr. Edwards (complete by X-11).
- Prepare position description, establish wage scale, place classified ad and begin recruitment of x-ray technologist (complete by X-15).
- Interview and select x-ray technologist: Drs. Smith and Edwards (complete by X-25).
- Continue until all steps have been described, assigned and given a time-line for completion.

This process will provide a methodical and soundly-based means of developing and accomplishing marketing objectives which will keep the practice flourishing in the future.

An added complication... in the treatment of bacterial bronchitis*


Increasing incidence of ampicillin resistance in Haemophilus influenzae
Ampicillin Resistant Haemophilus influenzae
H. influenzae
S. pneumoniae

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.$^{1-6}$

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile* Other causes of colitis should be ruled out

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e g, pressor amines, antihistamines, or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses Average levels were 0 18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour The effect on nursing infants is not known Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70)

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1 5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200)

[061782R]

---

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S pneumoniae* or *H influenzae*.[8]

Note Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information

References

1 Antimicrob Agents Chemother, *8* 91, 1975
2. Antimicrob Agents Chemother, *11* 470, 1977
3. Antimicrob Agents Chemother, *13*:584, 1978.
4 Antimicrob Agents Chemother, *12* 490, 1977
5 Current Chemotherapy (edited by W Siegenthaler and R. Luthy), II 880 Washington, D.C American Society for Microbiology, 1978
6. Antimicrob Agents Chemother, *13* 861, 1978
7 Data on file, Eli Lilly and Company
8 Principles and Practice of Infectious Diseases (edited by G L Mandell, R G Douglas, Jr, and J E Bennett), p 487 New York John Wiley & Sons, 1979

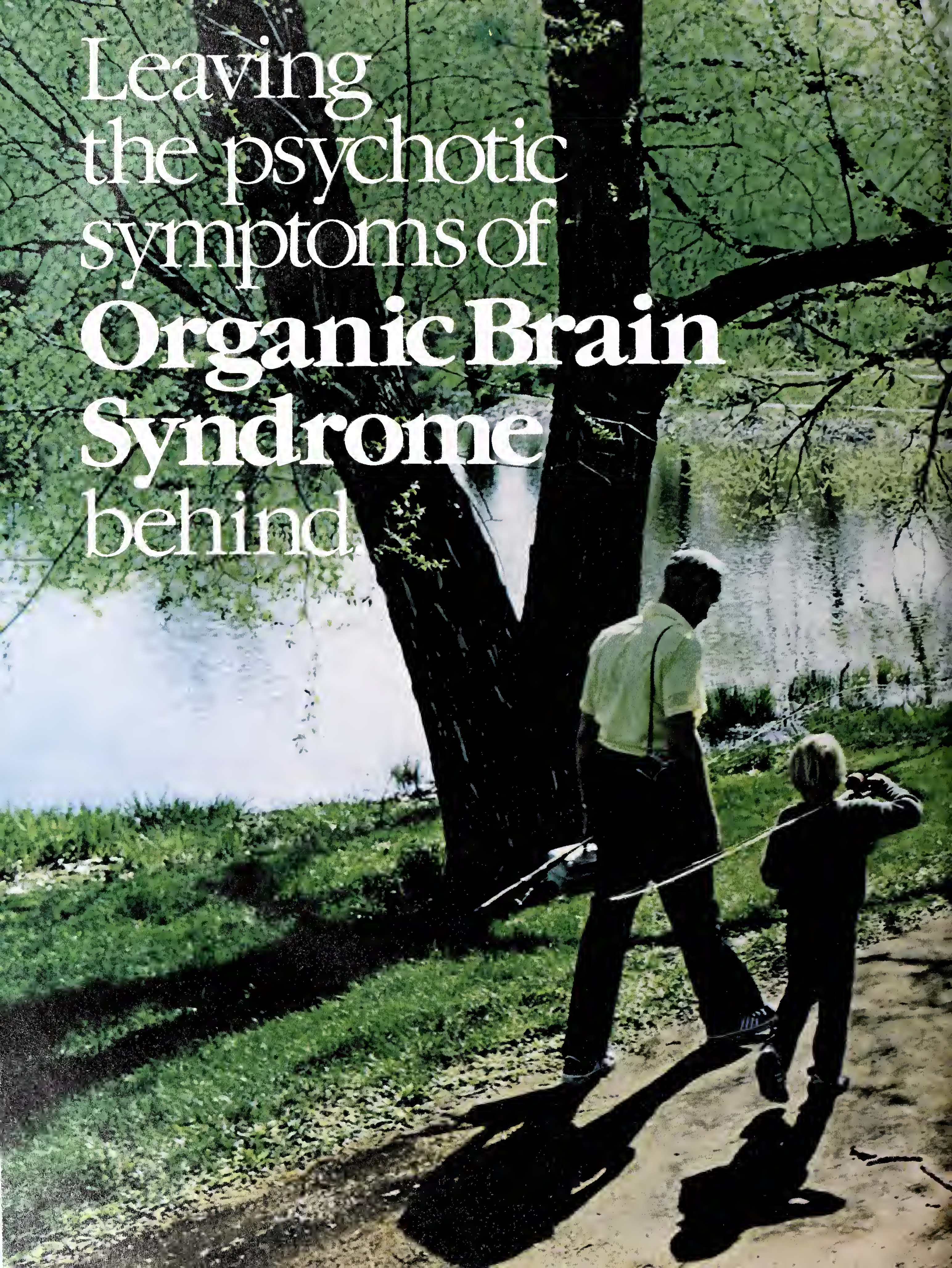
© 1982, ELI LILLY AND COMPANY

Lilly

Additional information available to the profession on request from
Eli Lilly and Company
Indianapolis, Indiana 46285.

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

300035


Leaving the psychotic symptoms of
Organic Brain Syndrome
behind.

Effective

Treatment with Navane can produce improvement in psychotic symptoms such as hallucinatory behavior and unusual thought content as well as hostility, disorientation and depressive mood,[1,2] leaving the elderly patient more alert[2] and better able to participate in the activities of family life.

Well tolerated

Navane is generally well tolerated by elderly patients. Excessive sedation or drowsiness has been reported, but is uncommon.[1] Anticholinergic effects[3] and hypotension[4,5] are reported, but rarely. Should they occur, extrapyramidal symptoms can usually be readily controlled.

Navane®

(thiothixene) (thiothixene HCl)

Capsules 1 mg, 2 mg, 5 mg, 10 mg, 20 mg
Concentrate 5 mg/ml Intramuscular 2 mg/ml, 5 mg/ml

See following page for a brief summary of prescribing information

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
at the forefront of psychopharmacology

© 1982, Pfizer Inc.

Navane®
(thiothixene) (thiothixene HCl)

References: 1. Util TM, Unverdi C, Wohlrade J, et al. Drug therapy of psychosis associated with organic brain syndrome. Presented as a Scientific Exhibit at the American Public Health Association Centennial, Atlantic City, New Jersey, November 12-16, 1972. 2. Katz MM, Util TM. Video methodology for research in psychopathology and psychopharmacology. *Arch Gen Psychiatry* 31:204-210, 1974. 3. Ketai R. Psychotropic drugs in the management of psychiatric emergencies. *Postgraduate Medicine* 58:87-93, 1975. 4. Birkett DP, Hirschfield W, Simpson GM. Thiothixene in the treatment of diseases of the senium. *Curr Ther Res* 14:775-779, 1972. 5. Data on file at Roerig.

BRIEF SUMMARY OF PRESCRIBING INFORMATION
Navane® (thiothixene) Capsules: 1 mg, 2 mg, 5 mg, 10 mg, 20 mg
(thiothixene hydrochloride) Concentrate: 5 mg/ml, Intramuscular: 2 mg/ml, 5 mg/ml

Contraindications: Navane (thiothixene) is contraindicated in patients with circulatory collapse, comatose states, central nervous system depression due to any cause, and blood dyscrasias. Navane is contraindicated in individuals who have shown hypersensitivity to the drug. It is not known whether there is a cross-sensitivity between the thioxanthenes and the phenothiazine derivatives, but the possibility should be considered.

Warnings: *Usage in Pregnancy*—Safe use of Navane during pregnancy has not been established. Therefore, this drug should be given to pregnant patients only when, in the judgment of the physician, the expected benefits from the treatment exceed the possible risks to mother and fetus. Animal reproduction studies and clinical experience to date have not demonstrated any teratogenic effects.

In the animal reproduction studies with Navane, there was some decrease in conception rate and litter size, and an increase in resorption rate in rats and rabbits, changes which have been similarly reported with other psychotropic agents. After repeated oral administration of Navane to rats (5 to 15 mg/kg/day), rabbits (3 to 50 mg/kg/day), and monkeys (1 to 3 mg/kg/day) before and during gestation, no teratogenic effects were seen. (See Precautions.)

Usage in Children—The use of Navane in children under 12 years of age is not recommended because safety and efficacy in the pediatric age group have not been established.

As is true with many CNS drugs, Navane may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery, especially during the first few days of therapy. Therefore, the patient should be cautioned accordingly.

As in the case of other CNS-acting drugs, patients receiving Navane should be cautioned about the possible additive effects (which may include hypotension) with CNS depressants and with alcohol.

Precautions: An antiemetic effect was observed in animal studies with Navane; since this effect may also occur in man, it is possible that Navane may mask signs of overdosage of toxic drugs and may obscure conditions such as intestinal obstruction and brain tumor.

In consideration of the known capability of Navane and certain other psychotropic drugs to precipitate convulsions, extreme caution should be used in patients with a history of convulsive disorders or those in a state of alcohol withdrawal since it may lower the convulsive threshold. Although Navane potentiates the actions of the barbiturates, the dosage of the anticonvulsant therapy should not be reduced when Navane is administered concurrently.

Caution as well as careful adjustment of the dosage is indicated when Navane is used in conjunction with other CNS depressants other than anticonvulsant drugs.

Though exhibiting rather weak anticholinergic properties, Navane should be used with caution in patients who are known or suspected to have glaucoma, or who might be exposed to extreme heat, or who are receiving atropine or related drugs.

Use with caution in patients with cardiovascular disease.

Also, careful observation should be made for pigmentary retinopathy, and lenticular pigmentation (fine lenticular pigmentation has been noted in a small number of patients treated with Navane for prolonged periods). Blood dyscrasias (agranulocytosis, pancytopenia, thrombocytopenic purpura), and liver damage (jaundice, biliary stasis) have been reported with related drugs.

Undue exposure to sunlight should be avoided. Photosensitive reactions have been reported in patients on Navane.

Neuroleptic drugs elevate prolactin levels; the elevation persists during chronic administration. Tissue culture experiments indicate that approximately one-third of human breast cancers are prolactin dependent *in vitro*, a factor of potential importance if the prescription of these drugs is contemplated in a patient with a previously detected breast cancer. Although disturbances such as galactorrhea, amenorrhea, gynecomastia and impotence have been reported, the clinical significance of elevated serum prolactin levels is unknown for most patients. An increase in mammary neoplasms has been found in rodents after chronic administration of neuroleptic drugs. Neither clinical studies nor epidemiologic studies conducted to date, however, have shown an association between chronic administration of these drugs and mammary tumorigenesis; the available evidence is considered too limited to be conclusive at this time.

Intramuscular Administration—As with all intramuscular preparations, Navane Intramuscular should be injected well within the body of a relatively large muscle. The preferred sites are the upper outer quadrant of the buttock (i.e. gluteus maximus) and the mid-lateral thigh.

The deltoid area should be used only if well developed, such as in certain adults and older children, and then only with caution to avoid radial nerve injury. Intramuscular injections should not be made into the lower and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.

Adverse Reactions: *Note:* Not all of the following adverse reactions have been reported with Navane (thiothixene). However, since Navane has certain chemical and pharmacologic similarities to the phenothiazines, all of the known side effects and toxicity associated with phenothiazine therapy should be borne in mind when Navane is used.

Cardiovascular effects: Tachycardia, hypotension, lightheadedness, and syncope. In the event hypotension occurs, epinephrine should not be used as a pressor agent since a paradoxical further lowering of blood pressure may result. Nonspecific EKG changes have been observed in some patients receiving Navane. These changes are usually reversible and frequently disappear on continued Navane therapy. The incidence of these changes is lower than that observed with some phenothiazines. The clinical significance of these changes is not known.

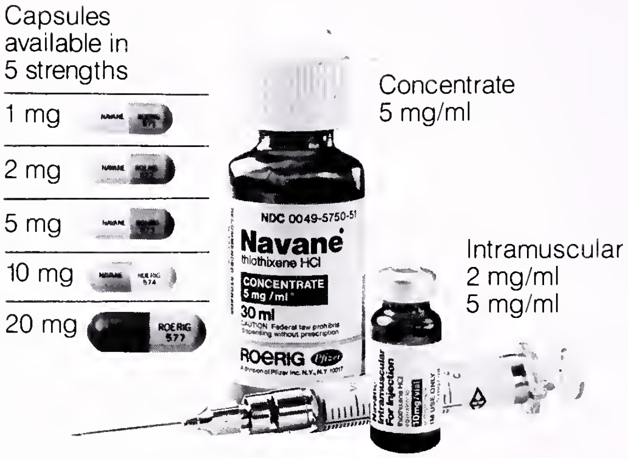
CNS effects: Drowsiness, usually mild, may occur although it usually subsides with continuation of Navane therapy. The incidence of sedation appears similar to that of the piperazine group of phenothiazines, but less than that of certain aliphatic phenothiazines. Restlessness, agitation and insomnia have been noted with Navane (thiothixene). Seizures and paradoxical exacerbation of psychotic symptoms have occurred with Navane infrequently.

Hyperreflexia has been reported in infants delivered from mothers having received structurally related drugs.

In addition, phenothiazine derivatives have been associated with cerebral edema and cerebrospinal fluid abnormalities.

Extrapyramidal symptoms, such as pseudo-parkinsonism, akathisia, and dystonia have been reported. Management of these extrapyramidal symptoms depends upon the type and severity. Rapid relief of acute symptoms may require the use of an injectable antiparkinson agent. More slowly emerging symptoms may be managed by reducing the dosage of Navane and/or administering an oral antiparkinson agent.

Persistent Tardive Dyskinesia: As with all antipsychotic agents tardive dyskinesia may appear in some patients on long term therapy or may occur after drug therapy has been discontinued. The risk seems to be greater in elderly patients on high-dose therapy, especially females. The symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Sometimes these may be accompanied by involuntary movements of extremities.


Capsules available in 5 strengths
1 mg
2 mg
5 mg
10 mg
20 mg
ROERIG 577
Concentrate 5 mg/ml
NDC 0049-5750-51
Navane
thiothixene HCl
CONCENTRATE 5 mg/ml
30 ml
CAUTION Federal law prohibits dispensing without prescription
ROERIG Pfizer
Intramuscular 2 mg/ml 5 mg/ml
Intramuscular For Injection

There is no known effective treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms of this syndrome. It is suggested that all antipsychotic agents be discontinued if these symptoms appear.

Should it be necessary to reinstitute treatment, or increase the dosage of the agent, or switch to a different antipsychotic agent, the syndrome may be masked.

It has been reported that fine vermicular movements of the tongue may be an early sign of the syndrome and if the medication is stopped at that time, the syndrome may not develop.

Hepatic effects: Elevations of serum transaminase and alkaline phosphatase, usually transient, have been infrequently observed in some patients. No clinically confirmed cases of jaundice attributable to Navane (thiothixene) have been reported.

Hematologic effects: As is true with certain other psychotropic drugs, leukopenia and leukocytosis, which are usually transient, can occur occasionally with Navane. Other antipsychotic drugs have been associated with agranulocytosis, eosinophilia, hemolytic anemia, thrombocytopenia and pancytopenia.

Allergic reactions: Rash, pruritus, urticaria, photosensitivity and rare cases of anaphylaxis have been reported with Navane. Undue exposure to sunlight should be avoided. Although not experienced with Navane, exfoliative dermatitis and contact dermatitis (in nursing personnel) have been reported with certain phenothiazines.

Endocrine disorders: Lactation, moderate breast enlargement and amenorrhea have occurred in a small percentage of females receiving Navane. If persistent, this may necessitate a reduction in dosage or the discontinuation of therapy. Phenothiazines have been associated with false positive pregnancy tests, gynecomastia, hypoglycemia, hyperglycemia, and glycosuria.

Autonomic effects: Dry mouth, blurred vision, nasal congestion, constipation, increased sweating, increased salivation, and impotence have occurred infrequently with Navane therapy. Phenothiazines have been associated with miosis, mydriasis, and adynamic ileus.

Other adverse reactions: Hyperpyrexia, anorexia, nausea, vomiting, diarrhea, increase in appetite and weight, weakness or fatigue, polydipsia and peripheral edema.

Although not reported with Navane, evidence indicates there is a relationship between phenothiazine therapy and the occurrence of a systemic lupus erythematosus-like syndrome.

NOTE: Sudden deaths have occasionally been reported in patients who have received certain phenothiazine derivatives. In some cases the cause of death was apparently cardiac arrest or asphyxia due to failure of the cough reflex. In others, the cause could not be determined nor could it be established that death was due to phenothiazine administration.

Dosage and Administration: Dosage of Navane should be individually adjusted depending on the chronicity and severity of the condition. In general, small doses should be used initially and gradually increased to the optimal effective level, based on patient response.

Some patients have been successfully maintained on once-a-day Navane therapy.

Usage in children under 12 years of age is not recommended because safe conditions for its use have not been established.

Navane Intramuscular Solution: Navane For Injection—Where more rapid control and treatment of acute behavior is desirable, the intramuscular form of Navane may be indicated. It is also of benefit where the very nature of the patient's symptomatology, whether acute or chronic, renders oral administration impractical or even impossible.

For treatment of acute symptomatology or in patients unable or unwilling to take oral medication, the usual dose is 4 mg of Navane Intramuscular administered 2 to 4 times daily. Dosage may be increased or decreased depending on response. Most patients are controlled on a total daily dosage of 16 to 20 mg. The maximum recommended dosage is 30 mg/day. An oral form should supplant the injectable form as soon as possible. It may be necessary to adjust the dosage when changing from the intramuscular to oral dosage forms. Dosage recommendations for Navane (thiothixene) Capsules and Concentrate appear in the following paragraphs.

Navane Capsules: Navane Concentrate—In milder conditions, an initial dose of 2 mg three times daily. If indicated, a subsequent increase to 15 mg/day total daily dose is often effective.

In more severe conditions, an initial dose of 5 mg twice daily.

The usual optimal dose is 20 to 30 mg daily. If indicated, an increase to 60 mg/day total daily dose is often effective. Exceeding a total daily dose of 60 mg rarely increases the beneficial response.

Overdosage: Manifestations include muscular twitching, drowsiness, and dizziness. Symptoms of gross overdosage may include CNS depression, rigidity, weakness, torticollis, tremor, salivation, dysphagia, hypotension, disturbances of gait, or coma.

Treatment: Essentially is symptomatic and supportive. For Navane oral, early gastric lavage is helpful. For Navane oral and Intramuscular, keep patient under careful observation and maintain an open airway, since involvement of the extrapyramidal system may produce dysphagia and respiratory difficulty in severe overdosage. If hypotension occurs, the standard measures for managing circulatory shock should be used (I.V. fluids and/or vasoconstrictors.)

If a vasoconstrictor is needed, levarterenol and phenylephrine are the most suitable drugs. Other pressor agents, including epinephrine, are not recommended, since phenothiazine derivatives may reverse the usual pressor action of these agents and cause further lowering of the blood pressure.

If CNS depression is present and specific therapy is indicated, recommended stimulants include amphetamine, dextroamphetamine, or caffeine and sodium benzoate. Stimulants that may cause convulsions (e.g. picrotoxin or pentylenetetrazol) should be avoided. Extrapyramidal symptoms may be treated with antiparkinson drugs.

There are no data on the use of peritoneal or hemodialysis, but they are known to be of little value in phenothiazine intoxication.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals

Treatment of the handicapped including 'Baby Does'

Important MSMS policies, particularly those of current interest, will be published in *Michigan Medicine* in coming months on this page. We begin with the policy on "Baby Does" and other handicapped persons. The policy was adopted January 18 by the MSMS Board of Directors.

Whereas, handicapped individuals possess equal rights within our society, and

Whereas, autonomous choice among alternatives is a right closely held by individuals within our society, and

Whereas, privacy and confidentiality are rights of both handicapped and non-handicapped individuals, and

Whereas, the family, physician, local social and religious agencies and courts best represent the values of those living within communities, and

Whereas, our local and state laws, procedures and policies must adhere to constitutional and statutory principles of our society as a whole; therefore be it

RESOLVED THAT:

1. Handicapped individuals have a right to choose among alternatives for care or treatment if competent to do so, and
2. Handicapped individuals unable to exercise their right of choice have the right to have choices made for them, and
3. Families provided with comprehensive information regarding alternatives can best represent the handicapped individual's desires if he or she is unable to express them, and
4. Protections provided by local agencies and courts may be invoked to evaluate family choices if questions regarding their validity with respect to the patient's best interest are conscientiously raised by the patient's physician or by the hospital bioethics committee.
5. Communities or physicians or hospitals can best assure society that a good decision-making process for treatment of the handicapped occurs by the following:
    - a. By aiding in the development of guidelines regarding the process of decision-making for treatment alternatives.
    - b. By providing counsel to families, physicians and agencies charged with individual decisions.
    - c. By confidential review of decision-making experiences.

The Michigan State Medical Society supports efforts to fully develop decision-making processes for treatment alternatives of the handicapped. However, the Michigan State Medical Society endorses only those decision-making processes that keep the individual patient or family in the primary role regarding specific choices for specific patients.

Background

On November 22, the Board of Directors received a report from the Committee on Public Service which contained the following recommendation:

> That the MSMS Board of Directors examine and discuss the development of an MSMS policy position on the "Baby Doe" issue because of the dangerous precedent being established through government intervention in personal decision making.

The Board referred the recommendation to the Task Force on Bioethics which discussed the issue in depth at its meeting of December 8. The issue arose out of concern over governmental intervention in the matter of a spina bifida child whose parents, upon the advice of their physicians and clergy, have made a decision not to subject the child to complicated and involved surgery which at best would extend the child's life without any improvement in the quality of life.

The Task Force reviewed information from the AMA and other health and medical organizations plus several articles which have recently appeared on the "Baby Doe" issue. The Task Force discussed the "Baby Jane Doe" situation in New York where an appeal has

SSTAF
Staffing Service To American Free-enterprise
Employee Leasing
Instant Relief from Employer Headaches

Find out how Employee Leasing can create a more lucrative pension plan for you, while lowering your management costs and improving employee benefits and job security. Write for FREE brochure, today!

I want to know more about SSTAF:

NAME ____________________

ADDRESS ____________________

CITY __________ STATE _____ ZIP _____

SSTAF **Mail to:**
Staffing Service To American Free-enterprise
2095 Niles Road, St. Joseph, MI 49085 (616) 983-1558
Corporate Headquarters: P.O. Box 1620, Charlotte Amalie, U.S. Virgin Islands 00801

been made to the U.S. Supreme Court to override a state court ruling that upheld the parents' wishes against the operation. In addition, there is federal legislation (HR 1904) and state legislation (SB 444) pending which would equate the withholding of any nutrition or medical and surgical intervention for handicapped children with child abuse and neglect and threaten funds for child abuse programs.

The federal proposal (HR 1904) would require the Secretary of HHS to develop procedural guidelines for establishing local health care mechanisms for the "review of care" provided to infants with life-threatening congenital impairments. States would be required, as a condition for receiving child abuse prevention grants, to have procedures "to ensure that nutrition, medically indicated treatment, general care, and appropriate social services are provided to infants at risk with life-threatening congenital impairments."

The AMA takes objection to the federal proposal in the following manner: "The American Medical Association opposes provisions of HR 1904 relating to infants at risk with life-threatening congenital impairments. We strongly disagree with the approach taken by the bill to deal with the complex issues of caring for infants with life-threatening congenital impairments. This approach could create disruption in the care of affected infants and harm the relationships between health care providers and their patients."

The AMA has recently published a booklet entitled, *Bioethical Opinions of the Judicial Council of the American Medical Association.* In the "Quality of Life" section, is the following statement regarding newborns:

> "In desperate situations involving newborns, the advice and judgment of the physicians should be readily available, but the decision whether to exert maximal efforts to sustain life should be the choice of the parents. The parents should be told the options, expected benefits, risks and limits of any proposed care; how the potential for human relationships is affected by the infant's condition; and relevant information and answers to their questions. The presumption is that the love which parents usually have for their children will be dominant in the decisions which they make in determining what is in the best interest of their children. It is to be expected that parents will act unselfishly, particularly where life itself is at stake. Unless there is convincing evidence to the contrary, parental authority should be respected."

Although the specific issue recommended for discussion by the Board of Directors revolved around "Baby Doe" situations, the Task Force on Bioethics is of the opinion that MSMS should have a policy statement which would encompass more than newborns.

Members of the Task Force are: Howard Brody, MD; Anna M.H. Broecker, MD; James T. Harrison, MD; John V. Hartline, MD; Sue A. Officer; Evan J. Reinders, MD; Marguerite Shearer, MD; Kornelius Van Goor, MD; and Lester Weiss, MD.

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android® /5 mg. Buccal /10 mg. Oral /25 mg. Oral
Methyltestosterone U.S.P. Tablets

ANDROID® /F
Fluoxymesterone U.S.P. Tablets, 10 mg.

NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Ricardo C. Alessio, MD — IM
158 N. Main St.
Plymouth 48170

Russell K. Ameter, MD — FP
85 Woolnough St.
Battle Creek 49017

John H. Arendshorst, MD —
OPH
155 W. 27th St.
Holland 49423

Walter F. Barkey, MD — D
2303 Stone Bridge Dr.
Flint 48504

Karen D. Barnes — WSU
1169 Maryland
Grosse Pte. Park 48230

David D. Baumgartner, MD —IM
776 56th St.
Kentwood 49508

Hans W. Bellinghausen, MD
7563 Leonard, N.E.
Ada 49301

Barry D. Binkley, MD — P
6856 Meadowlake
Birmingham 48010

Craig A. Bottke, MD — ORS
3544 Green Brier Blvd. #423A
Ann Arbor 48105

William A. Briggs, MD — IM/NEP
560 W. Mitchell
Petoskey 49770

Henry Brystowski, MD — IM/
RHU
14800 W. McNichols #401
Detroit 48235

Wayne B. Carlson, MD — FP
1000 Houghton
Saginaw 48602

Alan J. Conrad, MD — FP
140 Paluster St.
Cadillac 49601

Diana M. Constance, MD — P
1478 Sodon Court
Bloomfield Hills 48013

William A. Corsini, MD — GS
1050 S. Van Dyke
Bad Axe 48413

James W. Crowl, MD — IM
27240 Lathrup Blvd.
Lathrup Village 48076

Roy A. Davis, MD — GP
581 145th Ave.
Caledonia 49316

William H. Dery, MD — FP
4007 Orchard Dr.
Midland 48640

Ronald J. Dirkse, MD — CHP/P
675 E. 16th St., #250
Holland 49423

Jerome H. Dykstra, MD — FP/ EM
160 E. 31st St.
Holland 49423

Michael J. Eadie, MD — IM
3125 Lakehaven
Ann Arbor 48105

Sharon Y. Edwards, MD — OBG
237 Spinnaker
Lansing 48917

John W. Emo, MD — OBG
420 John St.
Kalamazoo 49007

Philip V. Fleming, MD — OBG
750 Towner
Ypsilanti 48197

Robert J. Friedhoff — WSU
994 Anita Ave.
Grosse Pte. Woods 48236

Vasudev R. Garlapaty, MD— OTO
3800 Woodward Ave. #1010
Detroit 48201

Steven H. Gollish, MD — GS
212 W. Sixth St.
Clare 48617

John D. Gray, MD — FP
Bell Medical Building
Ishpeming 49849

Rosalind E. Griffin, MD — P
16300 North Park Dr. #115
Southfield 48075

Scott A. Hawley, MD — PD/IM
1201 Stone St. #9
Port Huron 48060

James G. Herman, MD — R/C
P.O. Box 27307
Lansing 48909

John M. Hilu — WSU
4741 Second Ave. #2
Detroit 48201

Douglas E. Hoch, MD — IM/
PUL
409 Mid Oak Dr.
N. Muskegon 49445

Bruce S. Horowitz, DO — R/TR
3990 John R
Detroit 48201

Linda S. Hotchkiss, MD — P
14800 W. McNichols #208
Detroit 48235

Edward A. Jackson, MD — FP
1000 Houghton
Saginaw 48602

Bharti Jain, MD — GS
35 S. Johnson 3-D
Pontiac 48053

Edward N. Johnson, MD — FP
G-3245 Beecher Rd.
Flint 48504

Richard A. Joseph, MD — IM
21420 Harper
St. Clair Shores 48080

Hidayat A. Khan, MD — PD/A
1414 W. Fair Ave. #203
Marquette 49855

Wayne K. Kinning, MD — CDS
5119 W. Bristol Rd. A
Flint 48507

Howard D. Klosterman, MD —
R
2710 W. Court St. #12
Flint 48502

Richard S. Kowalczyk, PhD —
CLB
N. Mich. Hospitals, Inc.
Petoskey 49770

Peter Kowynia — WSU
26144 Virginia
Warren 48091

Kurt Kratz — WSU
3452 Three Mile Dr.
Detroit 48224

Timothy F. Kresowik, MD — GS
2852 Briarcliff
Ann Arbor 48105

Continued on page 178

YOUR INCOME
Employees' Salaries
OFFICE RENT
Utilities

COULD YOU MAINTAIN
YOUR OFFICE EXPENSES
DURING A PERIOD OF DISABILITY?

At age 40, your chances of becoming disabled for up to 6 months are 1 out of 3...1 out of 5 could be disabled up to 2 years...1 out of 7 could be disabled up to 5 years.*

You've probably insured your own income, but what about your employees' salaries, your office rent, your professional liability premiums, etc. etc. Check these features of the Professional Overhead Expense plan sponsored by the MSMS.

☑ Up to $3,000 monthly benefit
☑ Waiver of Premium
☑ Survivors' Benefits
☑ Professional liability premiums are a covered expense
☑ Expenses covered include rent, utilities, employees' salaries, accountant services, plus many more

"we're here to help"

Stratton–Cheeseman & Associates, Inc.
1305 Abbott Road • P.O. Box 1563 • East Lansing, Michigan 48823
Call Toll Free: **800-292-1966**

*1979. The National Underwriter Company

Louanda M. Kynhoff, MD — W
601 Brule Rd.
Marquette 49855

Stephen G. Landau, MD — P
2101 Country Club Rd.
Ann Arbor 48105

Violeta P. Lara, MD — AN
2000 Huntington St.
Marquette 49855

Lawrence O. Larson, MD — AN
1421 Crawford Lane
Ann Arbor 48105

Edward Lewis, MD — GS
1131 E. Howard City-Edmore Rd.
Edmore 48829

Hersell O. Lindo, MD — OBG
420 John St.
Kalamazoo 49007

Kenneth A. Lombardi, MD —
IM
50 North Ave.
Battle Creek 49017

Karl F. Loomis, MD — PTH
175 College St.
Battle Creek 49017

Thomas R. Macholan, MD — FP
2777 44th St., N.W.
Grand Rapids 49509

Omar A. Majid, MD — R
Henry Ford Hospital
Detroit 48202

Joseph W. Mashni, MD — U
701 N. Logan #220
Lansing 48915

Thomas L. McElwee, MD — IM
833 Lake Drive, SE
Grand Rapids 49506

Thomas Militano, MD — CD/TS
1414 W. Fair Ave.
Marquette 49855

Kristine E. Miller, MD — OBG
3075 Clark Rd. #206
Ypsilanti 48197

Anne E. Missavage, MD
2619 Holbrook
Hamtramck 48212

Barid B. Mukerjee, MD — IM
2900 Oakwood
Melvindale 48122

John A. Mulder, MD — FP
1675 Leahy
Muskegon 49442

Mario M. Nunez, MD — R
750 Lakeshore Dr.
Escanaba 49829

Agnes Ohno — WSU
201 E. Kirby #1206
Detroit 48202

Rich E. Olson, MD — NS
3535 W. 13 Mile Rd. #504
Royal Oak 48072

James D. Paauw, MD — GS
1520 Pine, NW
Grand Rapids 49504

Dennis J. Pank, MD — FP
2412 Robert T. Longway
Flint 48503

Samuel Perov, MD — AN
4201 St. Antoine
Detroit 48201

Lynn M. Podehl — WSU
42191 Dequindre
Sterling Heights 48075

Michael J. Post, MD — IM
543 Seminole
Fremont 49412

Donald N. Reed, Jr., MD — GS
401 N. Ballenger Hwy.
Flint 48503

Robert E. Reed, MD — IM/HEM
100 Michigan St., SE
Grand Rapids 49503

Jose A. Rodriguez, MD — IM
28532 Schoenherr Rd.
Warren 48093

Donald B. Roth, MD — N
560 W. Mitchell
Petoskey 49770

Katherine A. Roth, MD — FP
1222 E. Michigan
Lansing 48912

Diana M. Rothman, MD — ORS
2310 E. Stadium
Ann Arbor 48104

Todd W. Rudner — WSU
13455 Village Park Dr. C-1
Southgate 48195

Natalie A. Sabak, MD — FP
3430A Shadow Bend Dr.
Kalamazoo 49001

Thomas E. Sarosi, MD — R
560 W. Mitchell
Petoskey 49770

Sandra Schwarcz — MSU
1329 W. Grand River #82-C
East Lansing 48823

John C. Sennish, MD — GS
300 E. Chicago St.
Coldwater 49036

Kirit R. Shah, MD — IM/CVD
6001 W. Outer Dr. #330
Detroit 48235

Robert F. Stevenson, MD —
OPH
P.O. Box 119
Sault Ste. Marie 49783

William M. Suleiman, MD — GS
P.O. Box 36233
Grosse Pte. 48236

Christine M. Sullivan, MD —
GS
32427 Glen Cove
Farmington Hills 48018

Michael J. Sullivan, MD — OTO
32427 Glencove #14
Farmington Hills 48018

T. Russell Thompson, MD —
ORS
403 Bronson Medical Ctr., W.
Kalamazoo 49007

Arturo Velazquez, MD — FP
632 North Ave.
Battle Creek 49017

Steven E. Vorenkamp, MD —
ORS
560 W. Mitchell
Petoskey 49770

Paul A. Walk, MD — FP
632 North Ave.
Battle Creek 49017

Sharon S. Warnock, MD — FP
525 Lafayette St.
Ionia 48846

Mark Werner, MD — OBG
28477 Franklin #149
Southfield 48075

Martin F. Wieczorek, MD — OBG
27000 Franklin #224
Southfield 48034

John T. Wright, MD — EM
Chelsea Comm. Hosp.
Chelsea 48118

The AIDS Commitment

AIDS knows its business is serving physicians and their patients, who depend upon our dedication to deliver the best in diagnostic services.

AIDS ensures confidence by providing prompt, accurate and consistent testing services in a wide range of laboratory disciplines.

AIDS strives to conduct all business with integrity, skill and courtesy to each and every client.

AIDS intends to maintain excellence in skills and invest in research and development in order to better serve our clientele in the future.

AIDS understands that good service is the foundation of any business and the best service relies upon having the best people. Our staff of M.D.s, Ph.D.s, highly-skilled technologists and technicians, and AIDS' in-the-field PRO team assures the utmost in dependable, prompt, reliable service.

Allied Integrated Diagnostic Services (AIDS) is Michigan's fastest growing, most progressive full-service clinical laboratory. AIDS comprehensive diagnostic testing comprises a wide range of laboratory disciplines. We are ready to serve your laboratory needs 24 hours a day.

AIDS

ALLIED INTEGRATED DIAGNOSTIC SERVICES
22170 W. NINE MILE ROAD • SOUTHFIELD, MI 48034
313/352-5780
TOLL FREE NUMBER 1-800-AIDS LAB (243-7522)

Patients sought for U-M studies

Treatment for primary and metastatic liver cancer

Preliminary experience at the University of Michigan Medical Center with regional chemotherapy of liver metastases from colorectal cancer via a surgically implanted pump and hepatic artery catheter has been encouraging with achievement of an 80 to 85 percent response rate. A prospective randomized study to evaluate the additional benefit of combined systemic regional chemotherapy is underway. Patients eligible for this study need to have liver metastases from colorectal cancer. Newly diagnosed patients with the primary tumor in place as well as those previously resected and subsequently found to have liver metastases are eligible. Prior chemotherapy precludes eligibility for this study. However, such patients may be eligible for other forms of investigational therapy. In addition, patients with primary liver tumors or liver metastases from other gastrointestinal malignancies may be eligible for other studies. The referring physician may obtain information regarding patient eligibility and other details by contacting William Ensminger, PhD, MD or John Gyves, MD, University of Michigan Medical Center, Upjohn Center for Clinical Pharmacology, Ann Arbor, 48109 (313/764-5468).

Clinical Evaluation of Nivazol (WIN 27,914) in Patients with Pituitary-ACTH Dependent Cushing's Syndrome

In preliminary studies, Nivazol, a synthetic steroid analog, has been found to suppress plasma and urinary corticoid levels without apparent glucocorticoid metabolic effects. The present study is designed to test the possible use of Nivazol in patients with Cushing's disease. The study will determine if this drug can cause prolonged and sustained suppression of ACTH and cortisol secretion and clinical and biochemical remission of Cushing's syndrome. In preliminary studies, Nivazol has been found to be remarkably free of side-effects but the presence of side-effects with chronic administration of the drug will be investigated.

Patients who are required for the study are those with the diagnosis of pituitary-ACTH dependent Cushing's syndrome who are suppressible with large doses of dexamethasone. The cost for patient care will be covered from research funding. For details, contact David E. Schteingart, MD, professor of internal medicine, D4111 SACB, Box 02, University Medical Center, Ann Arbor 48109, 313/764-2216.

Maturity-Onset Type Diabetes of the Young

A subtype of noninsulin-dependent diabetes (NIDDM, Type II or maturity-onset type diabetes) is "maturity-onset type diabetes of the young" or "MODY." MODY can be suspected and recognized when NIDDM occurs in two, three or more generations. MODY can be recognized at a young age, under 25 to 30 years of age, and frequently starting in early adolescence, if looked for by routine plasma glucose testing. MODY diabetes is generally asymptomatic. A diagnosis of diabetes is usually not made in most members of such families until middle or late adult life, as in other types of NIDDM. Although MODY diabetes is inherited in an autosomal dominant fashion it appears heterogeneous in nature. We have identified families with very low insulin responses to glucose, other families with high insulin responses to glucose, some families with insulin resistance and some families who produce an abnormal insulin. Some families are resistant to the occurrence of vascular disease while other families have the typical microangiopathic and macroangiopathic complications of diabetes.

We are interested in studying more families with MODY diabetes. We would like to know of patients with Type II or maturity-onset type diabetes at any age in whose families diabetes occurs in more than one generation and preferably in more than one sibling. We can perform fasting plasma glucose and glucose tolerance tests in members of such families without any cost to the patient or his family since these studies are supported by research funds.

Since some families of MODY diabetes develop the severe micro and macro vascular complications of diabetes, it is of definite benefit to the patient to have the diabetes identified when it is asymptomatic. Such patients respond well to either diet therapy alone or diet plus oral agents for many decades.

For details, contact Stefan S. Fajans, MD, D4103 SACB, Box 02, University Medical Center, Ann Arbor 48109, 313/764-4165.

Autonomic Neuropathy in Diabetes

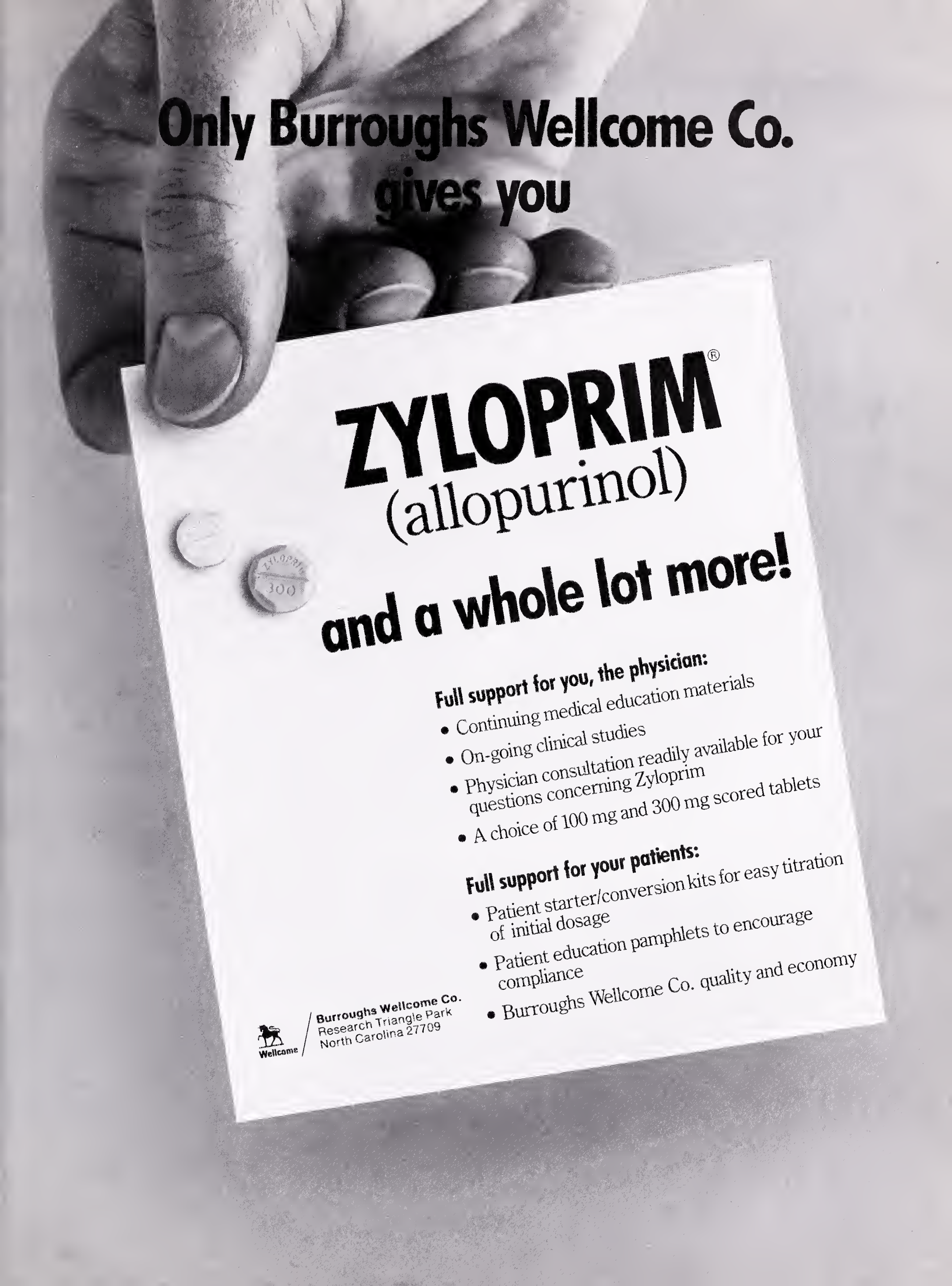
Patients with long-standing diabetes have a propensity to develop neuropathy involving the autonomic nervous sytem. A major problem relates to the severe orthostatic hypotension. We have shown that there may be defective receptors in some patients who can secrete norepinephrine, while others fail to secrete the neurotransmitter. These two ends of the spectrum dictate an entirely different therapeutic approach. We are currently evaluating the role of a new drug, Midodrine, which stimulates the alpha adrenergic receptor. We need patients for trial of Midodrine's therapeutic effectiveness.

For referrals, please contact A. Vinik, MD, SACB 2226, University Medical Center, Ann Arbor 48109, 313/763-5352.

Studies of Patients with Glycogen Storage Disease Type I (Von Gierke's Disease Glucose-6-Phosphatase Deficiency)

This study will examine the relationship between the response to hypoglycemia and accelerated ATP degradation in the liver. Patients will be hospitalized in the Clinical Research Center and have blood and urine collected to monitor hormone levels and metabolic intermediates. Prior to discharge the management of the glycogen storage disease will be optimized. Either adults or children may participate in the study. The cost of hospitalization for the research component of the admission will be paid by a grant from the Division of Research Resources, the National Institutes of Health.

For referrals, please contact Irving H. Fox, MD, professor, Internal Medicine, Room W4642 University Hospital, Clinical Research Center, Ann Arbor 48109, (313) 764-3240.



Only Burroughs Wellcome Co. gives you

ZYLOPRIM®
(allopurinol)

and a whole lot more!

Full support for you, the physician:

- Continuing medical education materials
- On-going clinical studies
- Physician consultation readily available for your questions concerning Zyloprim
- A choice of 100 mg and 300 mg scored tablets

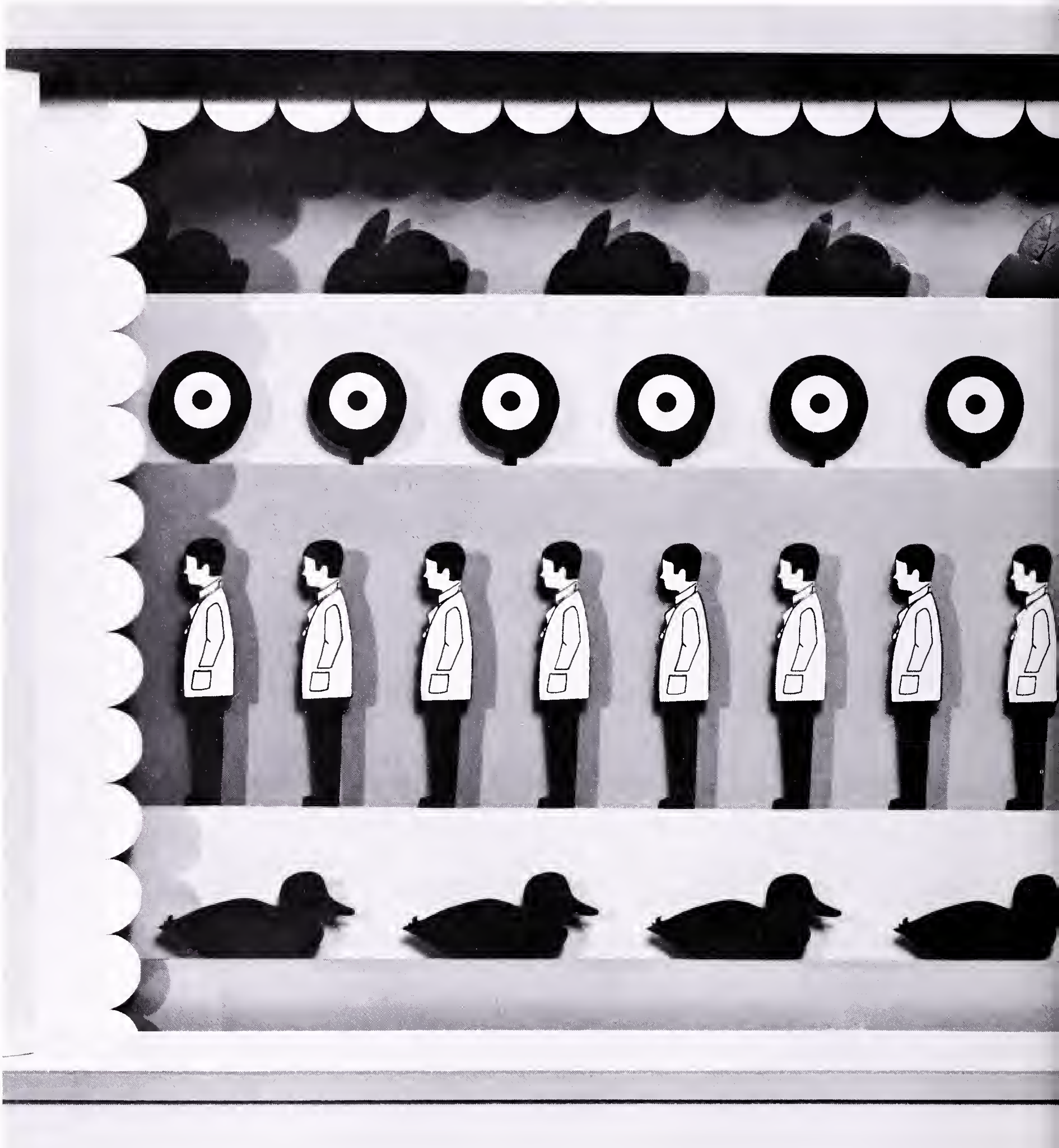
Full support for your patients:

- Patient starter/conversion kits for easy titration of initial dosage
- Patient education pamphlets to encourage compliance
- Burroughs Wellcome Co. quality and economy

Wellcome

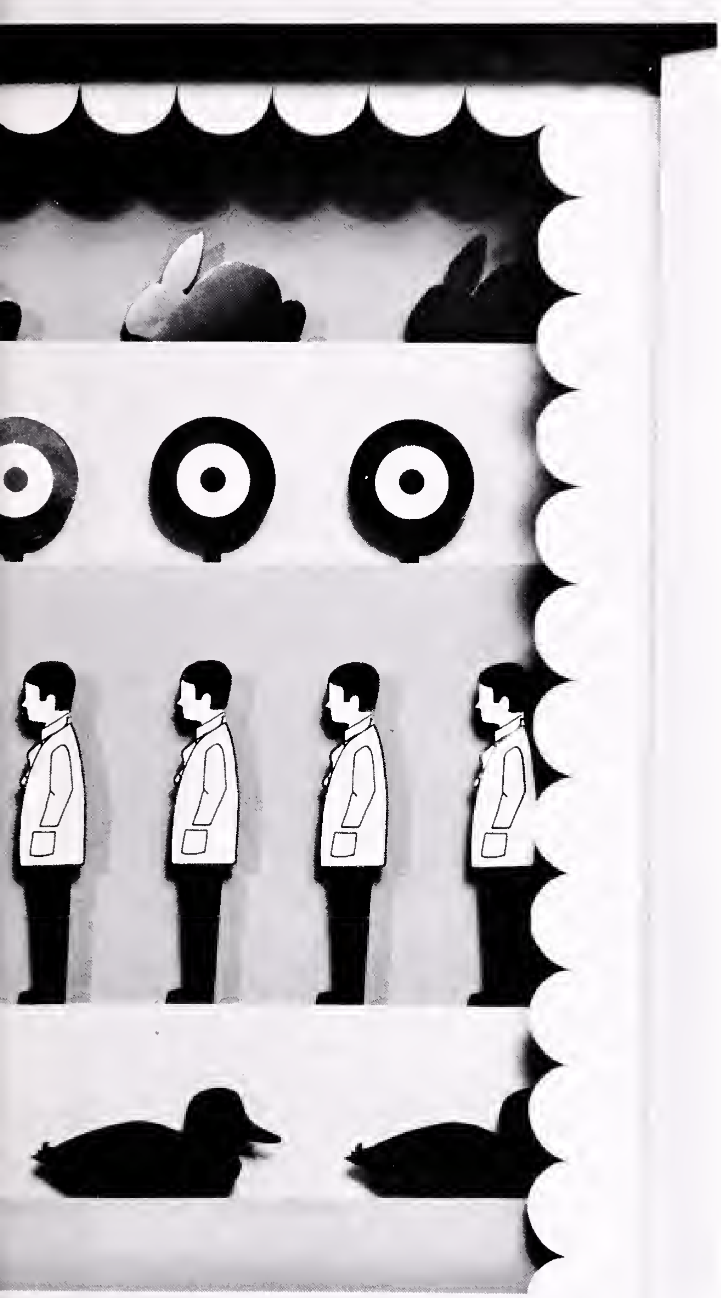
Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

If you become the target of a



©1983 MPMLC

professional liability claim...



You will be glad you have Michigan Physicians.

Michigan Physicians has been solving complex medical professional liability problems since 1976. With the state's largest and most experienced claims staff, Michigan Physicians works with you to resolve claims (and incidents) that most physicians have never faced in their careers.

In a changing legal environment, you need the best coverage you can buy because the risk of a professional liability claim is becoming greater every day.

For a confidential rate quotation and more information about Michigan's leading physician-owned insurance company, call or write the office in your area.

Michigan Physicians
Mutual Liability Company

1305 Abbott Road
East Lansing, MI 48823
(517) 351-1150
(800) 292-1926

6735 Telegraph Road
Suite 205
Birmingham, MI 48010
(313) 647-5550

Endorsed by the Michigan State Medical Society

By Millicent Lane

Compassion and patience virtues of Doctor Reizen

Doctor Reizen, by Lansing State Journal Chief Photographer Norris Ingells.

To Maurice S. Reizen, MD, retirement just means turning another corner in his career. His professional moves have taken him from private practice as a family physician in the Detroit area to top positions in state and national public health programs.

"That's what I've been wading through," he says as he points to a stack of green books on cancer control. They stand in a bookcase in an office he left when he retired Feb. 17 from state service.

Doctor Reizen doesn't propose to "stagnate in my declining years," but takes on new challenges as a private consultant working with local health departments and the National Cancer Institute. He says he wants to help NCI "build a bridge" to local and state health departments by making known its programs and opportunities for grants.

More pluses

In a way, this is an extension of his public health career, one that many would call remarkable. Doctor Reizen is happy he retires on a pleasant note.

"There have been a few low points; but, golly, there have been far more pluses than minuses," he remarks.

Doctor Reizen was state public health director from 1970 to 1980, during a period of remarkable growth in public health and unprecedented problems led by the PBB mishap in Michigan.

He says he wishes he'd had the foresight "to anticipate what PBB would have led us into." The

Continued on page 186

Ms. Lane is a *Lansing State Journal* reporter.

A NEW PROTOCOL
FOR THE
CONSERVATIVE TREATMENT
OF LOW BACK PAIN.

Plan now to attend the

1984 M.S.M.S. and W.A. Foote Memorial Hospital Seminar on a new method of treating low back pain

to be held

May 18—19, 1984

at

The Inn on Jackson Square in Jackson.

Earn Category I C.M.E. Credits and meet the experts in the low back field.

DOCTOR REIZEN/Continued

chemical PBB was accidentally mixed with animal feed in 1973 to 1974 in a mishap resulting in destruction of cattle and great economic loss to some Michigan farmers.

The PBB issue was overplayed by the press and that resulted in an atmosphere of hysteria, he says.

"My own assessment was I was never sure whether this was a scientific problem with political overtones, or a political problem with scientific overtones," he says.

To this day, he adds, the "impact of PBB on the human body is largely conjecture."

When things were really tough during the PBB problem, his wife, Leanor, gave him a wall hanging which reads: "If you're being run out of town, get in front of the crowd and make it look like a parade."

After Doctor Reizen resigned as state public health director, he served in several capacities in the Department of Public Health. Most recently, he has been medical deputy in the Bureau of Health Promotion and Disease Prevention and also served as acting chief of the bureau's child health division.

Child health has always been in the forefront of his interests. He established the first well-child clinic during his time as Ingham County public health director from 1966 to 1970.

With his colleagues in private practice, Doctor Reizen has always taken the stance of "an evolutionist and not a revolutionist." As a result, he says, he attempts to "promote change from within instead of screaming without."

Fictitious barrier

He's an active member of medical societies and attends meetings in Ingham County whenever possible.

"I've come to the realization that the so-called barrier between the private sector and public health is fictitious," he says. "In today's world, no one is exclusively private practice and no one can be exclusively public health, if for no other reason than because of where the funding comes from."

The day of the solo practitioner who took care of his private patients exclusively in his own office and received cash payment for his services no longer exists, Doctor Reizen says. That physician is "beholden to Medicare and Medicaid and private insurers. To me, that's no longer private."

When one looks at the ranks of private practice, academic practice, government-sponsored physicians, where is the greatest increase? It's in the government sector, he answers.

"Medical societies would be better off embracing all physicians in all walks of life, instead of adhering to the myth of being exclusively for the private sector," he says.

As a "government" physician, Doctor Reizen looks with pride at public health accomplishments in Michigan. He tops his list with the Public Health Code, which he calls "a monumental piece of legislation with great promise." That is despite the fact that one of the pillars of the code — cost sharing with local health departments — has not been fulfilled.

"The so-called barrier between the private sector and public health is fictitious."

"I'm patient enough now, or old enough now, to know that if you want to get something done, you can't get it done in an instant," he says.

Doctor Reizen may call patience his greatest virtue; but his oldest son, Bruce, who is with the Metropolitan Opera in New York City, says the one word that best describes his father is "compassion."

However he is described, Doctor Reizen is bound to continue to make his mark in the field of health.

This publication is available in microform.

University Microfilms International

Please send additional information for ________

Name ________

Institution ________

Street ________

City ________

State _____ Zip ________

300 North Zeeb Road
Dept P.R.
Ann Arbor, Mi. 48106
U.S.A.

30-32 Mortimer Street
Dept. P.R.
London W1N 7RA
England

Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

*

WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

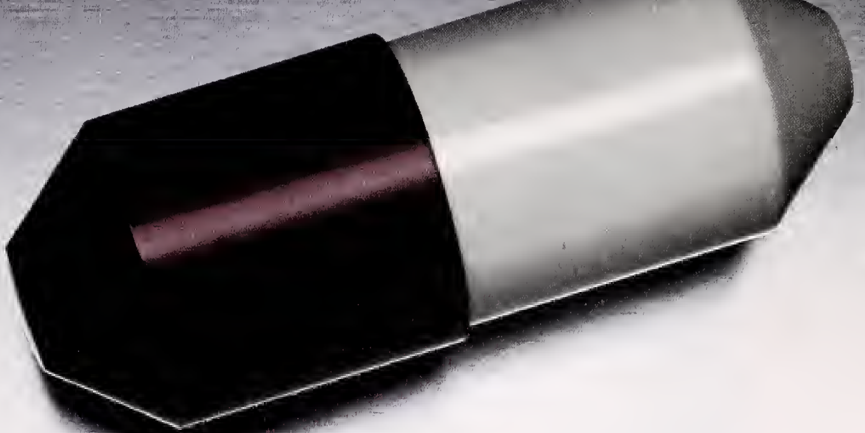
Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

In Hypertension*... When You Need to Conserve K^+

Remember the Unique Red and White Capsule: Your Assurance of SK&F Quality

*[illegible]



Potassium-Sparing
DYAZIDE®

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

Over 17 Years of Confidence

The unique
red and white
Dyazide® capsule:
Your assurance of
SK&F quality.

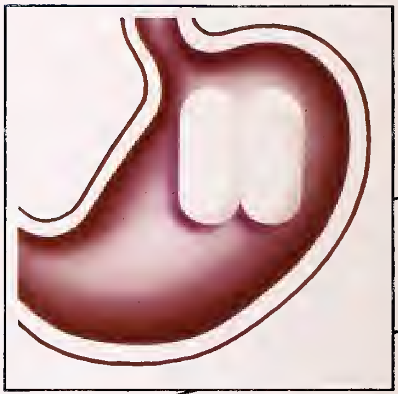
DYAZIDE
SKF

a product of
SK&F CO.
Carolina, P.R. 00630

©SK&F Co., 1983

ZORprin®
(ASPIRIN) ZERO ORDER RELEASE

Arthritis Therapy That Checks Out.



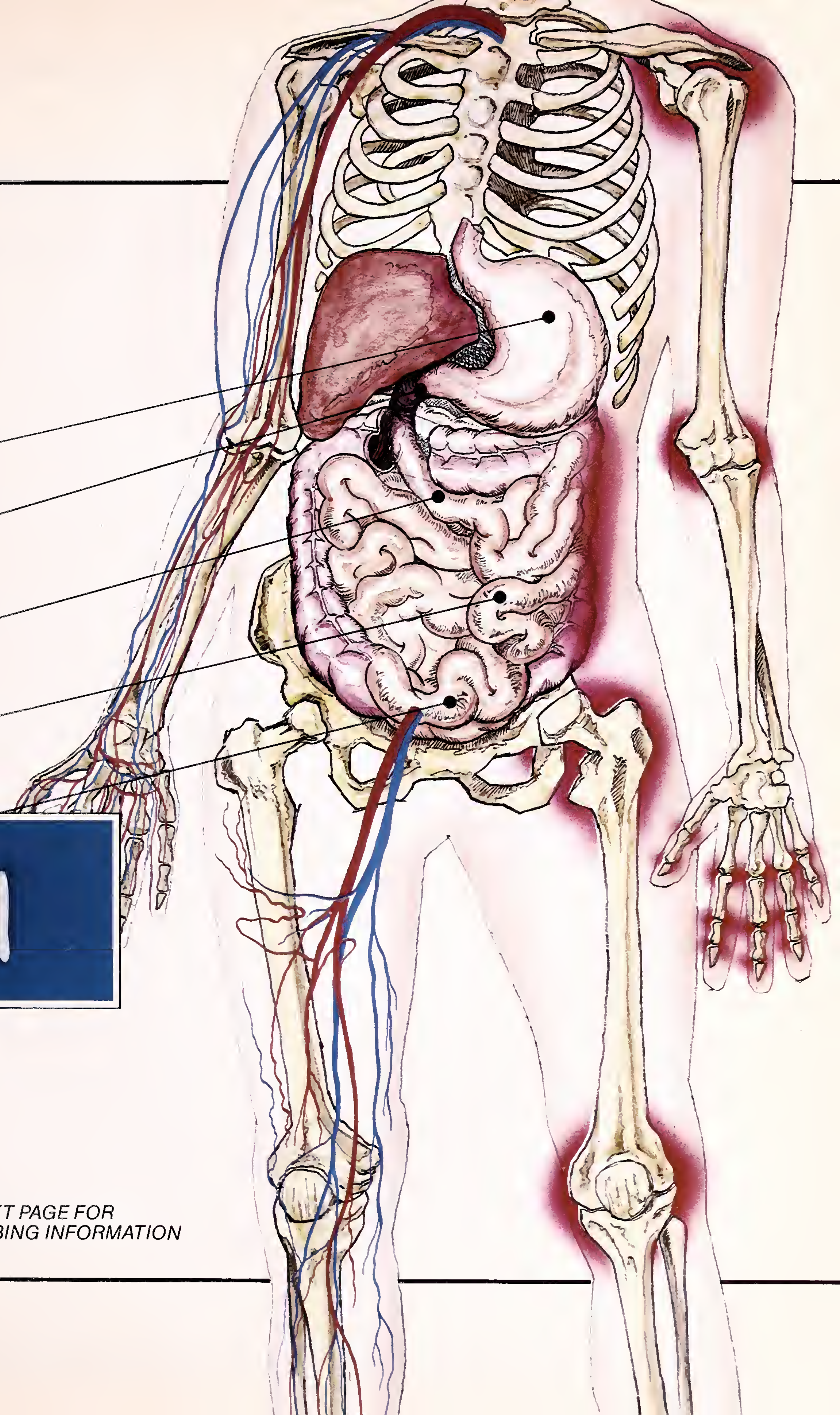
- ☑ Gastric distress is reduced. pH-dependent matrix virtually doesn't release in acidic stomach.
- ☑ ZORprin® (aspirin) is released in the alkaline environment of the small intestine.
- ☑ Zero-order release delivers drug at a constant rate, reducing serum peaks and valleys.

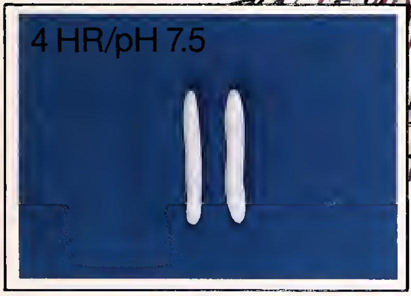
- ☑ Convenient b.i.d. dosage...enhances patient compliance.
- ☑ Economical...comparable efficacy and safety as other NSAIDs, yet costs approximately one-half as much.
- ☑ Your first step in arthritis therapy... **ZORprin®** (ASPIRIN) Zero-Order Release.

Pioneers in medicine for the family

Boots Pharmaceuticals, Inc.
6540 LINE AVENUE, P.O. BOX 6750
SHREVEPORT, LOUISIANA 71106-9989

© Boots Pharmaceuticals, Inc., 1983

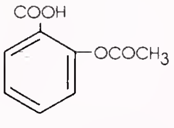




SEE NEXT PAGE FOR
FULL PRESCRIBING INFORMATION

ZORprin (ASPIRIN) Zero-Order Release

The structural formula of aspirin is:



DESCRIPTION: Each capsule-shaped tablet of Zorprin contains 800 mg of aspirin, formulated in a special matrix to control the release of aspirin after ingestion. The controlled availability of aspirin provided by Zorprin approximates zero-order release; the *in vitro* release of aspirin from the tablet matrix is linear and independent of the concentration of the drug. □ **CLINICAL PHARMACOLOGY:** Aspirin, as contained in Zorprin, is a salicylate that has demonstrated anti-inflammatory and analgesic activity. Its mode of action as an anti-inflammatory and analgesic agent may be due to the inhibition of synthesis of prostaglandins, although its exact mode of action is not known. □ Zorprin dissolution is pH-dependent. *In vitro* studies have shown very little aspirin to be released in acidic solutions; whereas, Zorprin releases the majority of its aspirin (90%) in a zero-order mode at a neutral to alkaline pH. It is this pH dependence of Zorprin that reduces direct contact between aspirin and the gastric mucosa, resulting in a reduction of its gastrointestinal side-effect potential. □ Bioavailability data for Zorprin have confirmed that plasma levels of salicylic acid and acetylsalicylic acid can be measured 24 hours after a single oral dose. This substantiates a twice daily dose regimen. Multiple dose bioavailability studies showed similar steady-state salicylate levels for Zorprin as for conventional release aspirin using the same total daily dose. Long-term monitoring of salicylate levels showed no signs of accumulation once steady-state levels were reached (4-6 days). □ Studies of *in vivo* prostaglandin levels (PGE2) have shown Zorprin plasma levels of salicylic acid and acetylsalicylic acid to reduce PGE2 levels 14 hours after a single oral 800 mg dose while an equivalent dose of aspirin produced a reduction of PGE2 levels only through six hours. Zorprin's effect on prostaglandins other than PGE2 has not been determined. □ Salicylates are excreted mainly by the kidney, and from studies in humans it appears that salicylate is excreted in the urine as free salicylic acid (10%); salicyluric acid (75%) salicylic phenolic (10%); acyl glucuronides (5%) and gentisic acid (<1%). □ **INDICATIONS & USAGE:** Zorprin is indicated for the treatment of rheumatoid arthritis and osteoarthritis. The safety and efficacy of Zorprin have not been established in those rheumatoid arthritic patients who are designated by the American Rheumatism Association as Functional Class IV (incapacitated, largely or wholly bedridden, or confined to wheelchair, little or no self-care). □ In patients treated with Zorprin for rheumatoid arthritis and osteoarthritis, the anti-inflammatory action of Zorprin has been shown by reduction in pain, morning stiffness and disease activity as assessed by both the investigators and patients. □ In clinical studies in patients with rheumatoid arthritis and osteoarthritis, Zorprin has been shown to be comparable to conventional release aspirin in controlling the aforementioned signs and symptoms of disease activity and to be associated with a statistically significant reduction in the milder gastrointestinal side effects (see ADVERSE REACTIONS). Zorprin may be well tolerated in some patients who have had gastrointestinal side effects with conventional release aspirin, but these patients when treated with Zorprin should be carefully followed for signs and symptoms of gastrointestinal bleeding and ulceration. □ Since there have been no controlled trials to demonstrate whether or not there is any beneficial effect or harmful interaction with the use of Zorprin in conjunction with other nonsteroidal anti-inflammatory agents (NSAI), the combination cannot be recommended (see **Drug Interactions**). □ **Because of its relatively long onset of action, Zorprin is not recommended for antipyresis or for short-term analgesia.** □ **CONTRAINDICATIONS:** Zorprin should not be used in patients known to be hypersensitive to salicylates or in individuals with the syndrome of nasal polyps, angioedema, bronchospastic reactivity to aspirin, renal or hepatic insufficiency, hypoprothrombinemia or other bleeding disorders. Zorprin is not recommended for children under 12 years of age; it is contraindicated in all children with fever accompanied by dehydration. □ **WARNINGS:** Zorprin should be used with caution when anticoagulants are prescribed concurrently, since aspirin may depress platelet aggregation and increase bleeding time. Large doses of salicylates may have hypoglycemic action and enhance the effect of the oral hypoglycemics, concomitant use therefore is not recommended. However, if such use is necessary, dosage of the hypoglycemic agent must be reduced. The hypoglycemic action of the salicylates may also necessitate adjustment of the insulin requirements of diabetics. □ While salicylates in large doses have a uricosuric effect, smaller amounts may reduce water excretion and increase serum uric acid. □ USE IN PREGNANCY: Aspirin can harm the fetus when administered to pregnant women. Aspirin interferes with maternal and infant hemostasis and may lengthen the duration of pregnancy and parturition. Aspirin has produced teratogenic effects and increases the incidence of stillbirths and neonatal deaths in animals. □ If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus. □ Aspirin should not be taken during the last 3 months of pregnancy. □ **PRECAUTIONS:** Appropriate precautions should be taken in prescribing Zorprin for patients who are known to be sensitive to aspirin or salicylates. Particular care should be used when prescribing this medication for patients with erosive gastritis, peptic ulcer, mild diabetes or gout. As with all salicylate drugs, caution should be exercised in prescribing Zorprin for those patients with bleeding tendencies or those on anticoagulants. □ In order to avoid exacerbation of disease or adrenal insufficiency, patients who have been on prolonged corticosteroid therapy should have their therapy tapered slowly rather than discontinued abruptly when Zorprin is made a part of the treatment program. □ Patients receiving large doses of aspirin and/or prolonged therapy may develop mild salicylate intoxication (salicylism) that may be reversed by dosage reduction. □ Salicylates can produce changes in thyroid function tests. □ Salicylates should be used with caution in patients with severe hepatic damage, preexisting hypoprothrombinemia, Vitamin K deficiency and in those undergoing surgery. □ Since aspirin release from Zorprin is pH dependent, it may change in those conditions where the gastric pH has been increased as a result of antacids, gastric secretion inhibitors or surgical procedures. □ **Drug Interactions:** (See **WARNINGS**) Aspirin may interfere with some anticoagulant and antidiabetic drugs. Drugs which lower serum uric acid by increasing uric acid excretion (uricosurics) may be antagonized by the concomitant use of aspirin, particularly in doses less than 2.0 grams/day. Nonsteroidal anti-inflammatory drugs may be competitively displaced from their albumin binding sites by aspirin. This effect may negate the clinical efficacy of both drugs. Also, the gastrointestinal inflammatory potential of nonsteroidal anti-inflammatory drugs may be potentiated by aspirin. The combination of alcohol and aspirin may increase the risk of gastrointestinal bleeding. □ Aspirin may enhance the activity of methotrexate and increase its toxicity. □ Sodium excretion produced by spironolactone may be decreased in the presence of salicylates. Concomitant administration of other anti-inflammatory drugs may increase the risk of gastrointestinal ulceration. Urinary alkalinizers decrease aspirin's effectiveness by increasing the rate of salicylate renal excretion. Phenobarbital decreases aspirin's effectiveness by enzyme induction. □ **Pregnancy Category D.** See **WARNINGS** Section. □ **Nursing Mothers:** Salicylates have been detected in the breast milk of nursing mothers. Because of the potential for serious adverse reactions from aspirin in nursing infants, a decision should be made whether to discontinue nursing or discontinue the drug, taking into account the benefit of the drug to the mother. □ **ADVERSE REACTIONS: Hematologic:** Aspirin interferes with hemostasis. Patients with a history of blood coagulation defects or receiving anticoagulant drugs or with severe anemia should avoid Zorprin. Aspirin used chronically may cause a persistent iron deficiency anemia. □ **Gastrointestinal:** Aspirin may potentiate peptic ulcer, and cause stomach distress or heartburn. Aspirin can cause an increase in occult bleeding and in some patients massive gastrointestinal bleeding. However, the greatest release of active drug from Zorprin is designed to occur in the small intestine over a period of time. This has resulted in fewer symptomatic gastrointestinal side effects. □ **Allergic:** Allergic and anaphylactic reactions have been noted when hypersensitive individuals have taken aspirin. Fatal anaphylactic shock, while not common, has been reported. □ **Respiratory:** Aspirin intolerance, manifested by exacerbations of bronchospasm and rhinitis, may occur in patients with a history of nasal polyps, asthma, or rhinitis. The mechanism of this intolerance is unknown but may be the result of aspirin-induced shunting of prostaglandin synthesis to the lipoxygenase pathway and the liberation of leukotrienes, *e.g.* slow-reacting substance of anaphylaxis. □ **Dermatologic:** Hives, rashes, and angioedema may occur, especially in patients suffering from chronic urticaria. □ **Central Nervous System:** Taken in overdoses, aspirin provides stimulation which may be manifested by tinnitus. Following initial stimulation, depression of the central nervous system may be noted. □ **Renal:** Aspirin rarely may aggravate chronic kidney disease. □ **Hepatic:** High doses of aspirin have been reported to produce reversible hepatic dysfunction. □ **OVERDOSAGE:** Overdosage, if it occurs, would produce the usual symptoms of salicylism: tinnitus, vertigo, headache, confusion, drowsines, sweating, hyperventilation, vomiting or diarrhea. Plasma salicylate levels in adults may range from 50 to 80 mg/dl in the mildly intoxicated patient to 110 to 160* mg/dl in the severely intoxicated patient. An arterial blood pH of 7.1 may indicate serious poisoning. The clearance of salicylates in children is much slower than adults and should receive due consideration when aspirin overdosages occur in infants; salicylate half-lives of 30 hours have been reported in infants 4-8 months old. Treatment for mild intoxication should include emptying the stomach with an emitic, or gastric lavage with 5% sodium bicarbonate. Individuals suffering from severe intoxication should, in addition, have forced diuresis by intravenous infusions of sodium bicarbonate and dextrose or sodium lactate. In extreme cases, hemodialysis or peritoneal dialysis may be required. □ (*A plasma salicylate level of 160 mg/dl in an adult is usually considered lethal.) □ **DOSAGE & ADMINISTRATION:** *In order to achieve a zero-order release, the tablets of Zorprin should be swallowed intact.* □ *Breaking the tablets or disrupting the structure will alter the release profile of the drug.* □ *It is recommended that Zorprin be taken with sufficient quantities of fluids (8 oz. or more).* □ **Adult Dosage:** For mild to moderate pain associated with rheumatoid arthritis and osteoarthritis, the recommended initial dose of Zorprin is 1600 mg (2-800 mg tablets) twice a day. Because of Zorprin's prolonged release of aspirin into the bloodstream, Zorprin tablets may be taken as a b.i.d. dose. Further adjustment of the dosage should be determined by the physician, based upon the patient's response and needs. Since it will take 4-6 days to reach steady-state levels of salicylic acid with Zorprin, it is recommended dosages be given for at least one week before further adjustment. In general, patients with rheumatoid arthritis seem to require higher doses of Zorprin than do patients with osteoarthritis. □ **Zorprin is not recommended for children below the age of 12.** □ **HOW SUPPLIED: Zorprin Tablets 800 mg;** plain, white capsule-shaped tablets. □ Bottles of 100 Tablets — NDC 0524-0057-01. □ **Caution:** Federal law prohibits dispensing without prescription. □ U.S. Patent No. 4,308,251. □ **Manufactured and Distributed by: BOOTS PHARMACEUTICALS, INC., Shreveport, Louisiana 71106 U.S.A.**

12/8/83 0057-04

Pioneers in medicine for the family

Boots Pharmaceuticals, Inc.
6540 LINE AVENUE, P.O. BOX 6750
SHREVEPORT, LOUISIANA 71106-9989

By Mert Scholten

FMGs 30 percent of MSMS members; nine percent are female

Foreign medical graduates (FMGs) comprise nearly 30 percent of the membership of the Michigan State Medical Society.

There were 2,579 FMGs active members of MSMS as of October 31, when the total active membership (full dues-paying members) numbered 8,698. This means 29.6 percent of the active members of MSMS graduated from a medical school outside the confines of the 50 states. When all classes of members, including students, residents, retired and life members combined, the FMG figure drops to approximately 26.5 percent.

In addition to the 2,579 FMGs identified as having active status, there are some 150 to 200 FMGs among the life and retired segments. Moreover, there are an estimated 600 FMGs practicing in the state who are not members of MSMS.

2,263 of the FMGs are male, 303 are female. MSMS is able to determine that *at least* 46 married physician couples are among the active numbers.

The national figures on FMGs show a total of 102,762, or 21.2 percent, of the total U.S. physicians. As a percentage of the active total, the FMGs account for 20.0 percent of the national physician population. Thus, Michigan is nearly 10 percent *above* the national average in percentage of FMGs.

A foreign medical graduate is defined as any graduate of a medical school outside the borders of the United States. The term applies equally to foreign nationals and to United States citizens trained in foreign schools.

The 2,579 active-member FMGs come from 95 different medical schools in 77 different countries.

India has supplied the greatest number with 555, while the Philippines is second with 369 doctors as members. Canada is third with 196, followed by South Korea with 194. Iran is the only other nation supplying Michigan with more than 100 doctors, claiming 111 active MSMS members.

These five nations account for 1,425 active MSMS members, or 55 percent of the total FMG membership.

Pakistan with 88, Germany with 86, Turkey with 63, Thailand with 53, Argentina with 52, Taiwan (Formosa) with 52, and Egypt with 51 active MSMS members

Countries in which Michigan's FMGs trained

Country	Total
India	555
Philippines	369
Canada	196
South Korea	194
Iran	111
Pakistan	88
Germany	86
Turkey	63
Thailand	53
Argentina	52
Taiwan (Formosa)	52
Egypt (United Arab Repub.)	51
Mexico	47
Syria	46
Ireland	46
England (including Wales)	33
Peru	32
Iraq	31
Cuba	28
Columbia	26
Italy	23
Spain	22
Greece	21
Scotland	20
Lebanon	20
Poland	20
Yugoslavia	18
Austria	17
Switzerland	15
China	13
Israel	13
Czechoslovakia	12
Dominican Republic	12
France	12
Hungary	12
Netherlands	12
South Africa	11
Japan	11
Paraguay	10
Brazil	9
South Vietnam	9
Bangladesh	8
Montserrat	8
Sri Lanka	7
Australia	6
Bolivia	5
El Salvador	5
Haiti	5
Romania	5
Russia	5
Belgium	4
Ecuador	4
Guatemala	4
Indonesia	4
Nigeria	4
Burma	3
East Africa (Uganda)	3
Jamaica	3
Bulgaria	2
Chile	2
Latvia	2
Lithuania	2
New Zealand	2
Uruguay	2
Denmark	1
Finland	1
Ghana	1
Honduras	1
Malta	1
Nicaragua	1
Norway	1
Panama	1
Sweden	1
Venezuela	1
West Indies	1
Unidentified foreign schools	2
	2,579

Mr. Scholten is chief, MSMS Section on Public and Medical Relations.

have supplied more than 50 members to MSMS. The breakdown is attached.

FMG Distribution by County

We might expect foreign-trained physicians in Michigan to concentrate in major cities with large teaching hospitals, and to a certain extent this pattern emerges. Clearly, the largest numbers of FMGs are found in the counties with high concentrations of physicians. Wayne has 1,042 FMG active MSMS members; Oakland has 333; Genesee claims 177 and Macomb counts 143 FMG members.

However, some of the less populated and more rural counties may actually have higher percentages of foreign physicians. At least nine such counties show FMG memberships greater than 40 percent.

The phenomenon may be due to a variety of circumstances. On the one hand, the increasing numbers of physicians is expanding all physician services (including those of FMGs) into less populated areas as physicians seek adequate patient bases to support a viable practice.

In other cases, one or two FMGs began practices in areas where physician services were desperately needed, and have become woven into the community fabric. Later they may have been jointed by colleagues, friends and others of the same ethnic group or geographic proximity.

The phenomenon of physicians electing to establish practices within a 50 or 75 mile radius of their last training base accounts, perhaps, for the numbers of FMGs in the proximity of teaching hospitals.

The breakdown of MSMS active FMG members by county (with the percent of FMGs in proportion to all members) is as follows:

Counties in which FMGs reside

County	FMGs in membership	% of total members
Allegan	2	5.8
Alpena (includes Presque Isle)	5	10.6
Bar:y	1	3.8
Bay/Arenac/Iosco	38	32.3
Berrien	40	24.5
Branch	6	24.0
Calhoun	33	18.8
Cass	4	44.0
Chippewa/Mackinac	3	11.5
Clinton	5	50.0
Delta	3	8.8
Dickinson/Iron	3	6.6
Eaton	2	11.7
Genesee	177	37.3
Grand Traverse/Leelenau/Benzie	8	6.5
Gratiot	6	22.0
Hillsdale	3	15.7
Houghton/Baraga/Keweenaw	15	36.5
Huron	13	44.8
Ingham	69	14.7
Ionia	12	33.3
Isabella	8	17.7
Jackson	38	25.8
Kalamazoo	61	13.4
Kent	60	8.5
Lapeer	14	48.2
Lenawee	27	38.5
Livingston	18	50.0
Luce	2	28.5
Macomb	143	45.2
Manistee	4	26.6
Marquette	21	19.8
Mason	6	20.6
Mecosta	2	7.4
North Central (Crawford, Gladwin Kalkaska, Montmorency Ogemaw, Oscoda, Otsego & Roscommon)	10	17.2
Midland	13	12.0
Monroe	26	43.3
Muskegon	21	10.5
Northern MI (Antrim, Charlevoix, Emmett, Cheboygan)	14	12.6
Oakland	333	27.2
Oceana	1	12.5
Ottawa	5	4.2
Saginaw	80	32.5
St. Clair	44	38.2
St. Joseph	13	36.1
Sanilac	8	50.0
Schoolcraft	2	25.0
Shiawassee	7	16.6
Tuscola	11	47.8
VanBuren	8	28.5
Washtenaw	81	12.8
Wayne	1,042	31.6
Wexford	4	12.9

Specialty choices

Medical specialty choices pursued by Michigan's FMGs would appear to arrange themselves proportionately to specialties elected by American medical school graduates.

Internal medicine is the most commonly designated specialty among MSMS' active FMG members, with 496.

General surgery is second with 281. Obstetrics/gynecology ranks third with 222 practitioners.

Anesthesiology captures fourth place with 197, followed by family/general practice listing 186 physicians among the FMGs.

Pediatrics, psychiatry, radiology and pathology round out the specialties claiming 100 or more active MSMS FMG members. The breakdown is attached.

Popular FMG Specialties

Internal Medicine	496
General Surgery	281
Obstetrical Gynecology	222
Anesthesiology	197
General/Family Practice	186
Pediatrics	170
Psychiatry (including child)	162
Radiology	150
Pathology	115
Urological Surgery	73
Cardiology	54
Orthopedic Surgery	38
Thoracic Surgery	37
Neurology	36
Ophthalmology	35
Neurosurgery	31
Otorhinolaryngology	29
Plastic Surgery	25
Dermatology	21
Physical Medicine & Rehabilitation	16
Allergy (including ped. allergy)	16
Occupational Medicine	14
Cardiovascular Surgery	10
Colon & Rectal Surgery	10
Emergency Medicine	10
Pulmonary Diseases	9
Gastroenterology	8
Neoplastic Disease/Oncology	8
Nuclear Medicine	8
Encocrinology	7
Hematology	7
Abdominal Surgery	4
Hand Surgery	4
General Preventive Medicine	4
Infectious Diseases	3
Rheumatology	3
Pediatric Cardiology	2
Pediatric Surgery	2
Psychosomatic Diseases	2
Diabetes	1
Public Health	1
Other Specialties than designated above	15
Specialty not given	57

Continued on page 194

The AMA puts current information at your fingertips.

The first nationwide medical information network brings a new dimension to the way in which physicians and other health care professionals keep abreast of the latest knowledge in their profession.

Now, through the use of a low-cost computer terminal or personal computer, you can have instant access to authoritative and up-to-date information. The American Medical Association's computerized data bases place a wide range of professional resources at your fingertips, such as clinical, administrative, medical practice information, and abstracts of current clinical literature. Physicians can earn Category I, Continuing Medical Education (CME) credit using the Massachusetts General Hospital Continuing Medical Education programs or can elect to use the MGH-CME programs as informational updates or refresher courses.

Adding a new dimension to the way in which you communicate is MED/MAIL electronic mail. With the same terminal, you can send messages to your colleagues across the country or across the city . . . in minutes.

Information that could take hours to acquire through traditional channels can now be gathered in minutes, giving you valuable extra time for other important activities. And you can use the medical information network at your convenience, 24 hours a day, from your office, hospital or home.

It's surprisingly economical and professionally indispensable.

GTE Telenet
Medical Information Network

FOR SUBSCRIPTION INFORMATION PLEASE CONTACT
PHYSICIAN SERVICE GROUP, INC.
A member service subsidiary of the
MICHIGAN STATE MEDICAL SOCIETY
EAST LANSING, MICHIGAN

Ellen Vinocur Potash
Telephone 517/337-1351

GTE

Do you know

a physician
with problems
of alcoholism,
drug abuse,
emotional illness
or other
difficulties
which interfere with
his or her ability
to practice medicine?

If so, please contact your MSMS Program to Assist Impaired Physicians through Katie Brewbaker at MSMS headquarters, (517) 337-1351.

FMGs/Continued

Distribution of female members

Numbers of female physicians in Michigan are increasing proportionately to the numbers of female medical students, the numbers of female residents and the efforts to attract females into the ranks of organized medicine.

Board of Medicine figures indicate 1,371 females hold Michigan medical licenses. Of these, 780 are active MSMS members in Michigan. Another 16 female physician members reside out of state. The figures used here do not include female medical students or residents. Thus, 56.8 percent of the potential active MSMS female membership is currently on the membership rolls.

Nine percent of active dues-paying MSMS members are female. This compares with the national figure of 11.8 percent. The 1,371 licensed females (exclusive of residents) are approximately 11 percent of the active physicians in Michigan. Nationally, female physicians comprise 12.2 percent of total physicians. Thus, Michigan is somewhat below average in practicing female physicians.

All indications are that the number of female physicians will expand rapidly, as approximately one-third of all entering medical students today are female. Michigan State University College of Human Medicine actually had a recent entering class with 51 percent female members.

The distribution of female physicians in Michigan appears to be fairly even. The greatest numbers are found in the most populous cities and counties, but 47 of the 57 component societies have one or more female members.

Of the 780 female members in the state, 306 or 39 percent are foreign medical graduates. India has contributed 91, the Philippines 92, Germany 16 and Canada 10. The rest are scattered among 34 different countries. The breakdown of female physicians by county is attached.

Female physician distribution by Michigan component societies (MSMS members only)

Allegan	1
Alcona	1
Arenac	5
Berrien	11
Calhoun	12
Chippewa	2
Delta	3
Dickinson	1
Eaton	4
Genesee	37
Grand Traverse	3
Gratiot	1
Houghton	4
Huron	1
Ingham	43
Ionia	4
Isabella	2
Jackson	10
Kalamazoo	21
Kent	40
Lapeer	7
Lenawee	6
Livingston	8
Macomb	35
Manistee	1
Marquette	8
Mason	2
Mecosta	1
Menominee	1
Montmorency	3
Midland	5
Monroe	9
Muskegon	10
Newaygo	1
N. Michigan (Antrim, Charlevoix, Cheboygan, Emmet)	9
Oakland	91
Oceana	1
Ottawa	5
Saginaw	14
St. Clair	3
St. Joseph	4
Sanilac	1
Shiawassee	2
Tuscola	2
Washtenaw	56
Wayne	288
Wexford	1
Total	780

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

1st FOR PROFESSIONAL PROTECTION EXCLUSIVELY

YOUR FIRST STEP TO FIRST QUALITY PROTECTION
CONTACT FIELD REPRESENTATIVES

Eastern Office
JOHN K. GALLOWAY, THOMAS A. WEISMAN, WAYNE M. BACKUS,
MARK A. TISDEL and CHARLES J. ROWE
6785 Telegraph Road, Suite 350, Birmingham, Michigan 48010
(313) 647-6640

Western Office
GEORGE J. HAWORTH
2600 Five Mile Road, NE, Suite 101
Grand Rapids, Michigan 49505
(616) 361-0863

ARIZONA MEDICAL CAREERS
Health Care Industry . . . Sun Valley Country

Our client, a growth oriented, integrated health care organization, with hospitals and clinics in the Southwest, requires Board eligible or certified general practitioners and medical/surgical specialists for new and established practices.

We are particularly interested in physicians for internal medicine, family practice, pediatrics, obstetrics, gynecology, oncology, orthopedics, otolaryngology, general surgery and anesthesiology.

Here is an opportunity to work in a rural setting offering a substantial practice with outdoor recreational potential second to none. Sound interesting? Based on your financial needs, our client will offer appropriate income guarantees, incentives, relocation expenses and total malpractice insurance.

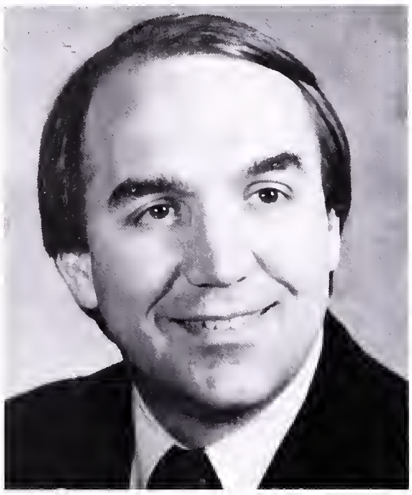
Please send your curriculum vitae and professional references.

Suite 311-D
3020 E. Camelback Rd.
Phoenix, AZ 85016

an equal opportunity employer m/f/h

By Carole Eberly

New Senate majority leader sees competitive world ahead



Sen. Engler

His navy blue suit, white shirt and red and white pin-striped tie shout "Republican." However, the man inside is calm, soft-spoken and deliberate, measuring his words as carefully as a jeweler weighs gold.

Meet Sen. John Engler, the new senate majority leader. Engler was chosen to lead his fellow Republicans in the top spot after two Democratic senators were defeated in recall elections in the Detroit area. The voters' replacement of the Democrats with two Republicans meant the 20-18 split enjoyed by the Democrats was reversed. It's the first time in a decade the Republicans have had control of either house of the legislature.

Several firsts

But then, Sen. Engler, whose district includes the counties of Midland, Osceola, Mecosta, Gratiot, Clare and Isabella, is used to firsts.

In 1972 he became the youngest legislator elected to the House by defeating Rep. Russell Strange, a 14-year veteran. He was 22 at the time.

Another first came when he married a legislative colleague, Rep. Colleen House. They were the first husband-wife team to serve in the Michigan Legislature. Fortunately, for marital harmony, Rep. House was a Republican. And so, there is still a Rep. Engler in the House today.

In the 1978 primaries, John Engler challenged Sen. John F. Toepp, a 12-year veteran, and won. He went on to win the general election with nearly 79 percent of the vote in the 36th district.

With his political experience Sen. Engler's in a good position to interpret the recent Senate alignment for Michigan physicians.

"I think it means that there's a very independent Senate that's free of domination by organized labor," Sen. Engler said. "It means that issues will be faced more objectively and in more timely fashion.

I think that physicians are like other people in this state," he continued. "They want state government that gives full value for tax dollars utilized. And one of the obligations that we as Republicans feel as the majority is the obligation to make sure that we're closely attentive to how taxpayer dollars are spent."

Sen. Engler said that means making sure state government doesn't grow larger than it needs to, and that it doesn't attempt to do more than it effectively can.

He said the most obvious change for physicians is the "complete reshuffling of the cast of characters who will be prominent in the news and in dealing with interest groups such as MSMS."

For example, the Public Health Subcommittee now is chaired by Sen. Connie Binsfield, R-Maple City. Sen. David Holmes, D-Detroit, was the previous head of the committee.

In addition, the Health and Social Services Committee, formerly chaired by Sen. Patrick McCollough, D-Dearborn, was revamped to the Education and Health Committee, now chaired by Sen. Paul Henry, R-Grand Rapids.

Also, the Commerce Committee, previously headed by Sen. Art Miller, D-Warren, is now chaired by Sen. Dick Posthumus, R-Lowell. This committee has broadened its scope so that all insurance and business regulatory issues will go through it.

All of the recasting took Sen. Engler two weeks to orchestrate — a job that usually takes about twice that long during the beginning of normal legislative sessions.

Talented group

"We're serious about the tasks at hand," Sen. Engler said. "We're a talented group. We want to make a significant contribution. We want to make a difference."

He talks like a man who wants to make up for lost time, and who wants to deliver a new vision of where Michigan should be going.

"Republicans are more cognizant of the fact that the glory that was once ours (Michigan's) will never be recreated," Sen. Engler said. "We're going to have to create a new future that is different from the past."

In order to do that, Sen. Engler said Michigan must get its economic house in order by competing for jobs, by reducing costs and by eliminating special

Continued on page 198

Ms. Eberly is a Lansing-area freelance writer.

Competence counts

Hurley Medical Center photo

In selecting a doctor, 74 percent of Americans consider competence, not cost.

Competent doctors remain the key to health. But competence isn't immunity to litigation.

Consider our competence – and our professional liability protection and strong-defense philosophy.

We defend you against non-meritorious claims. We won't settle a claim without your approval or merely to cut our defense cost.

PiCOM
Physicians Insurance Company Of Michigan
4277 Okemos Rd., Box 1000
Okemos, Michigan 48864
(517) 349-6500
(313) 557-4845
1-800-292-1036

privileges that in some cases have raised costs and made Michigan less attractive to employers.

"And we're going to have to make a sizeable investment in education," he said.

He said there was no question that education was an investment in the future of Michigan.

"The employment needs in this state can only be met by having a well-trained, well-educated work force," he said. "And that's true whether we're talking about jobs on the line, operating some new high-technology equipment that's coming into manufacturing processes, engineers designing the processes or marketing managers in the services. We have a tremendous need to improve our communications, engineering and managerial skills."

He said "grandiose schemes" that government can lead the private sector back to prosperity have not worked.

"In other words, old programs redesigned and reenacted to try to solve old problems don't work," he said.

"When we (Republicans) look at those problems we conclude that Michigan's future cannot be divorced from that of the other 49 states or even from other countries around the world. It's going to be a very competitive world in which we're going to have to be extremely well-prepared to survive."

Engler pointed to the varied roles of physicians in the health care delivery system as an example of the changes underway.

"I think physicians are no different than many segments of society today. We're in a time of transition and there will be roles in the future that perhaps are inconceivable today. Market forces and competition will, in large part, dictate those changes."

Physicians' role

What is the physicians' role in the economic system?

Sen. Engler said physicians have been substantial taxpayers in the past.

"An economic system doesn't normally categorize persons as physicians or farmers or teachers," he said. "From a public policy standpoint I would think we'd concern ourselves with creating a competitive environment where men and women can practice their professions and make their investments according to their own training and skills. They'll have an opportunity to succeed on the basis of their own abilities rather than by mastering an arcane set of government rules and regulations."

But, what about licensure, a government regulatory function?

"Licensure is an appropriate state function when it is used to achieve a purpose of assuring minimal competency of a profession or occupation," Sen. Engler said. "It doesn't always work because there are exceptions in medicine or dentistry or law or homebuilding where individuals can successfully meet a state requirement but fall short in terms of delivering the kind of care the public expects."

He said when those situations arise, it's important to have the regulatory process resolve the issue.

"No occupation or profession is well-served by the retention of inadequate individuals with inadequate skills," he said. "And I think in the case of the medical profession that the Medical Practices Board has to be supported and it has to be given the tools with which to act."

At the same time, however, he said due process must be afforded every individual.

"But there should not be the ability to use those protections to needlessly delay disciplinary action if appropriate," he said.

Malpractice views

What are Sen. Engler's views on medical malpractice?

"There has to be a balance between the rights of the public to have an appropriate standard of care versus the matter of the practitioner to be free from harassment and excessive costs in order to provide that acceptable level of care at a reasonable cost," he said. "I think the legislature has to be very careful any time it considers legislation that alters the balance too far one way or the other."

Sen. Engler said the scope of practice of health care professionals also is in transition. And the disputes arising from scope of practice areas are best settled between the parties involved, he said.

"Unfortunately that isn't always possible. Then the legislature is compelled to intervene."

He brought up the recent case of disagreement between optometrists and ophthalmologists which had to be settled in the legislature.

"The final legislative product never fully satisfied either group," Sen. Engler said.

He warned that when the legislature is called in to arbitrate disputes, "it's fair to say going in the outcome is never certain.

"There's a possibility for someone to lose more than they thought possible — more than they would have lost if an agreement would have been reached outside the legislature."

A phone rings on Sen. Engler's desk. His next appointment is awaiting him, and it's only three hours before the Monday evening session.

He turns and glances out of the window before walking to the door. His view overlooks the capital complex behind the statehouse.

It's a good view for someone who wants to see a shift away from the massive state spending of the 1970s. It serves as a reminder that the legislature is "going to have to create a new future that is different from the past."

ELECTIONS '84

In the upcoming 1984
elections Michigan
voters will elect
a U.S. Senator,
18 Congressmen and
110 State
Representatives

MDPAC

MDPAC

MICHIGAN DOCTORS POLITICAL ACTION COMMITTEE

MDPAC *needs* your financial support in order to contribute to the campaigns of candidates responsive to the concerns of the medical profession. It is in the political arena that the major decisions affecting the medical profession are being made. Make a professional membership investment in

MDPAC

An MDPAC investment:

- Reflects physician commitment to political action and results
- Represents a large physician "precinct" motivated to **influence the political and legislative processes that affect the practice of medicine**
- **Provides a coordinated means for medicine to support candidates who recognize and promote the aims of the medical profession**

MDPAC Regular Membership	$ 50.00
MDPAC Sustaining Membership	$150.00

(All sustainers receive an MDPAC sustainer pin.)

MDPAC contributions should be written on a personal check

MDPAC, P.O. Box 769, East Lansing, MI 48823

LABORATORY OF CLINICAL MEDICINE

MID-MICHIGAN REFERENCE LABORATORY, II, Inc.
(517) 372-8180

1322 E. Michigan Ave.
Suite 211
Lansing, Michigan 48912

930 E. Mt. Hope Ave.
Lansing, Michigan 48910

2909 E. Grand River Ave.
Suite 104
Lansing, Michigan 48912

W. E. Maldonado, M.D.
Director

Robert B. Foy, Ph.D.
Chief Executive Officer

Ann E. Chernys, M.D.
John W. Dyke, Ph.D.
Dennis E. Freer, Ph.D.
John J. Gillespie, M.D.
Ronald N. Horowitz, M.D.
John R. Kateley, Ph.D.

LABORATORY OF CLINICAL MEDICINE
MID-MICHIGAN REFERENCE LABORATORY

John J. Lyday, M.D.
Joseph R. Melvin, Ph.D.
Sandra K. Shirley, M.D.
Laurence R. Simson, Jr., M.D.
Susan M. Strate, M.D.
Irene K. Trombley, M.D.

REFERENCE LABORATORY FOR SPECIALIZED PROCEDURES
Specimen Pickup and Delivery of Test Results Daily
House calls are available upon Physician's request
Assignment is accepted from Medicare, Medicaid, Blue Shield and all other insurance carriers.

By Deborah Zannoth

PROM actively pursuing Michigan PRO contract

The Physician's Review Organization of Michigan is a subsidiary of MSMS and the Michigan Association of Osteopathic Physicians and Surgeons. PROM was formed by the MSMS House of Delegates in 1982, and given funds by the 1983 House of Delegates to become operational. PROM was incorporated on January 19, 1983 and currently holds two contracts for private review services, one with Blue Cross and Blue Shield of Michigan and the other with Michigan Education Special Services Association.

The Federal Peer Review Act of 1982 mandates that statewide peer review organizations (PROs) will be responsible for reviewing inpatient Medicare services, and the government's Prospective Payment System (PPS/DRG) requires hospitals to contract with a PRO for review in order to receive payment from Medicare.

PROM intends to bid for the PRO contract in Michigan. The update below is of current PROM activity.

PROM update

After organizations around the country had waited months, the Federal Health Care Finance Administration finally announced its readiness for proposals for the PRO contract on February 27. All completed contract proposals must be received at HCFA by 2 pm EST Friday, April 27. HCFA also released at this time the two remaining regulations, one of which deals with the organizational structures and the other which designates the geographical area for PROs.

In anticipation of this event, the PROM Board of Directors took action to divide the state into four administrative units which will subcontract with PROM to provide local peer review services (see map). Region 1, primarily the eastern portion of Michigan, has 117,000 hospital discharges per year. Region 2, the Northwestern section of Michigan has 99,500. Region 3, Wayne County, will remain as a single unit and has 94,800 discharges. Region 4, the southern section of Michigan, has 86,000 discharges. These administrative units will be self-governing and will be designated based upon bids secured from legally qualified physician-sponsored review organizations.

Within the PROM proposal for the PRO is a requirement that review offices be maintained in each area where there is currently a PSRO, and that there be active involvement of the local physician population.

PROM will be altering the former PSRO arrangement by establishing the four administrative units which subcontract with the statewide organization.

A significant difference from PSRO review, which focused retroactively on intensity of services delivered and on length of stay, the PRO review will focus on establishing the appropriateness of admissions. Portions of the PRO review will be conducted as care is underway.

Under the PRO, data submitted will be forwarded by PROM to a regional or local peer review entity for completion of the actual review process. An organization composed of physicians will review physician services, examining appropriateness and quality of care obtained during the hospital stay.

PRO functions

All PROs are required to perform the following functions:

1) *Verify diagnostic information provided by the hospital.* This requires the PRO to validate the accuracy of the DRG assigned to a patient's care by examining the medical record.

2) *Review the appropriateness of hospital admission.* This information is secured by the PRO through hospital medical records. If the admission is found to be inappropriate, the hospital will not receive Medicare reimbursement for the service.

3) *Review day and cost "outliers."* Each DRG has guidelines for length of stay and cost. If a patient hospital stay exceeds either, the PRO will verify the DRG, review the admission, and determine the amount of payment for necessary services.

4) *Perform quality of care studies.*

At this time, PROM is the only physician organization in the state prepared to make a bid for the PRO contract. Should PROM fail in its efforts, the government alternative will be to use the fiscal intermediary or some other private business organization.

PROM, therefore, is quite intent on securing the PRO contract and assuring Michigan physicians their traditional right to review colleagues' delivery of care.

Ms. Zannoth is assistant, MSMS Section on Medical Economics and Reimbursement.

Laboratory Facilities: Advance Medical & Research Center, Inc. laboratory services and operations have been designed to meet the growing needs of Michigan's medical community. In addition to our main laboratory, located in Pontiac, we have client service centers and branch laboratories in most major outstate communities.

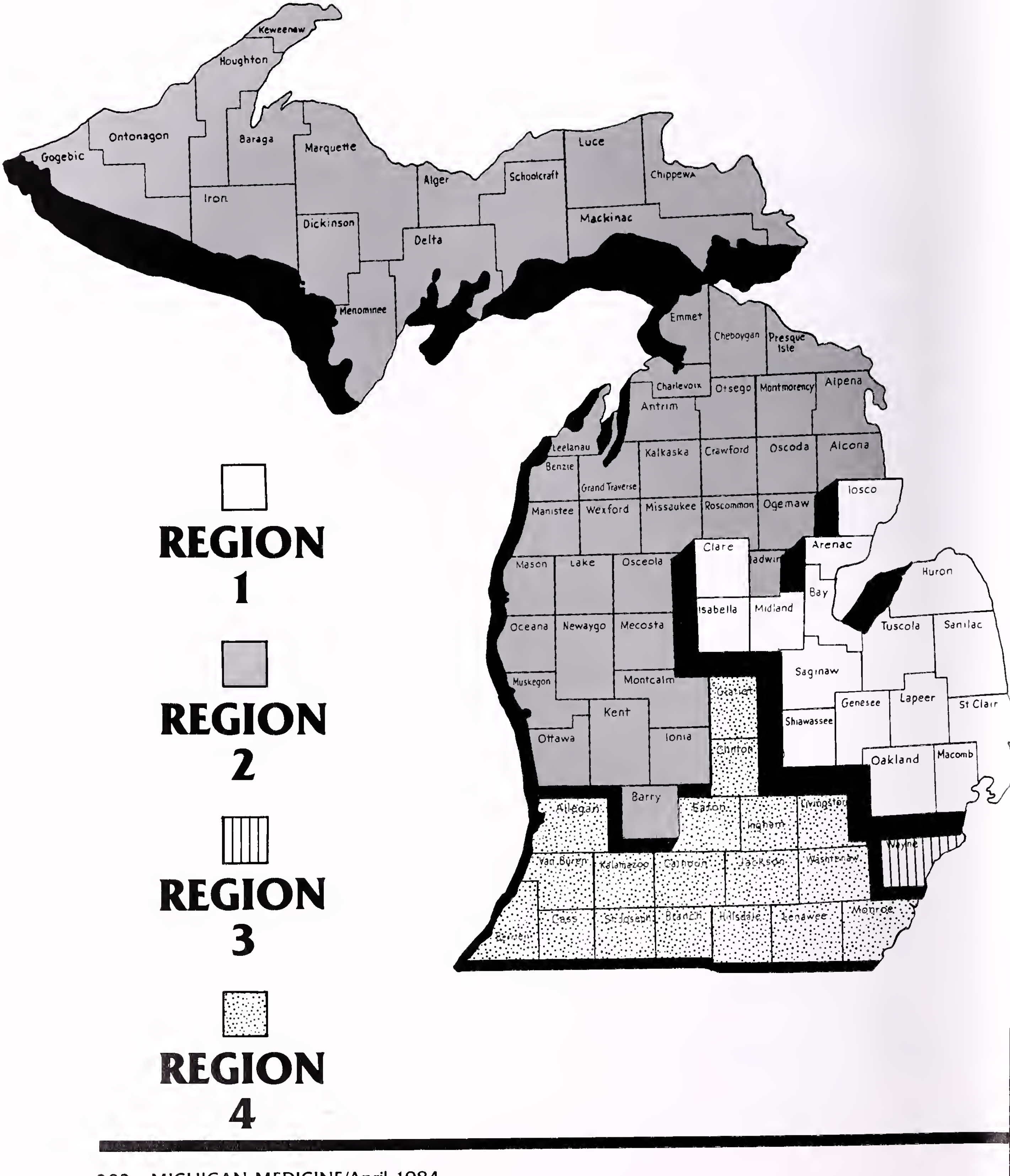
ADVANCE MEDICAL & RESEARCH CENTER, INC.

1270 Doris Rd. • Pontiac, Michigan 48057 • (313) 373-9120

Branches: Allen Park, Alpena, East Jordan, Flint,
Grand Rapids, Kalamazoo, Lansing, Monroe, Traverse City

Serving the medical profession since 1963

PROM REGIONS


Keweenaw
Houghton
Ontonagon
Gogebic
Baraga
Marquette
Luce
Chippewa
Alger
Schoolcraft
Iron
Mackinac
Dickinson
Delta
Menominee
Emmet
Cheboygan
Presque Isle
Charlevoix
Otsego
Montmorency
Alpena
Antrim
Leelanau
Benzie
Kalkaska
Crawford
Oscoda
Alcona
Grand Traverse
Manistee
Wexford
Missaukee
Roscommon
Ogemaw
Iosco
Clare
Arenac
adwi
Mason
Lake
Osceola
Huron
Bay
Isabella
Midland
Tuscola
Sanilac
Oceana
Newaygo
Mecosta
Saginaw
Muskegon
Montcalm
Gratiot
Genesee
Lapeer
St Clair
Kent
Shiawassee
Ottawa
Ionia
Clinton
Oakland
Macomb
Barry
Allegan
Eaton
Livingston
Ingham
Wayne
Van Buren
Kalamazoo
Calhoun
Jackson
Washtenaw
Cass
St Joseph
Branch
Hillsdale
Lenawee
Monroe
Berrien
☐ REGION 1
▨ REGION 2
▥ REGION 3
░ REGION 4

Motrin®

ibuprofen, Upjohn

600 mg Tablets

MOTRIN 600mg
More convenient for your patients.

Upjohn

© 1984 The Upjohn Company

The Upjohn Company • Kalamazoo, Michigan 49001 USA

J-4044 January 1984

Photo: Peter B. Kaplan

If you still believe in me, save me.

For nearly a hundred years, the Statue of Liberty has been America's most powerful symbol of freedom and hope. Today the corrosive action of almost a century of weather and salt air has eaten away at the iron framework; etched holes in the copper exterior.

On Ellis Island, where the ancestors of nearly half of all Americans first stepped onto American soil, the Immigration Center is now a hollow ruin.

Inspiring plans have been developed to restore the Statue and to create on Ellis Island a permanent museum celebrating the ethnic diversity of this country of immigrants. But unless restoration is begun now, these two landmarks in our nation's heritage could be closed at the very time America is celebrating their hundredth anniversaries. The 230 million dollars needed to carry out the work is needed now.

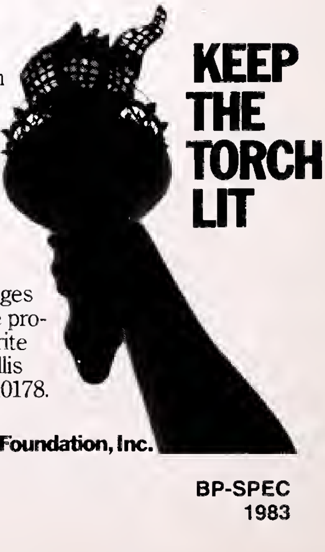
All of the money must come from private donations; the federal government is not raising the funds. This is consistent with the Statue's origins. The French people paid for its creation themselves. And America's businesses spearheaded the public contributions that were needed for its construction and for the pedestal.

The torch of liberty is everyone's to cherish. Could we hold up our heads as Americans if we allowed the time to come when she can no longer hold up hers?

Opportunities for Your Company.

OFFICIAL SPONSOR LIBERTY

You are invited to learn more about the advantages of corporate sponsorship during the nationwide promotions surrounding the restoration project. Write on your letterhead to: The Statue of Liberty-Ellis Island Foundation, Inc., 101 Park Ave, N.Y., N.Y. 10178.

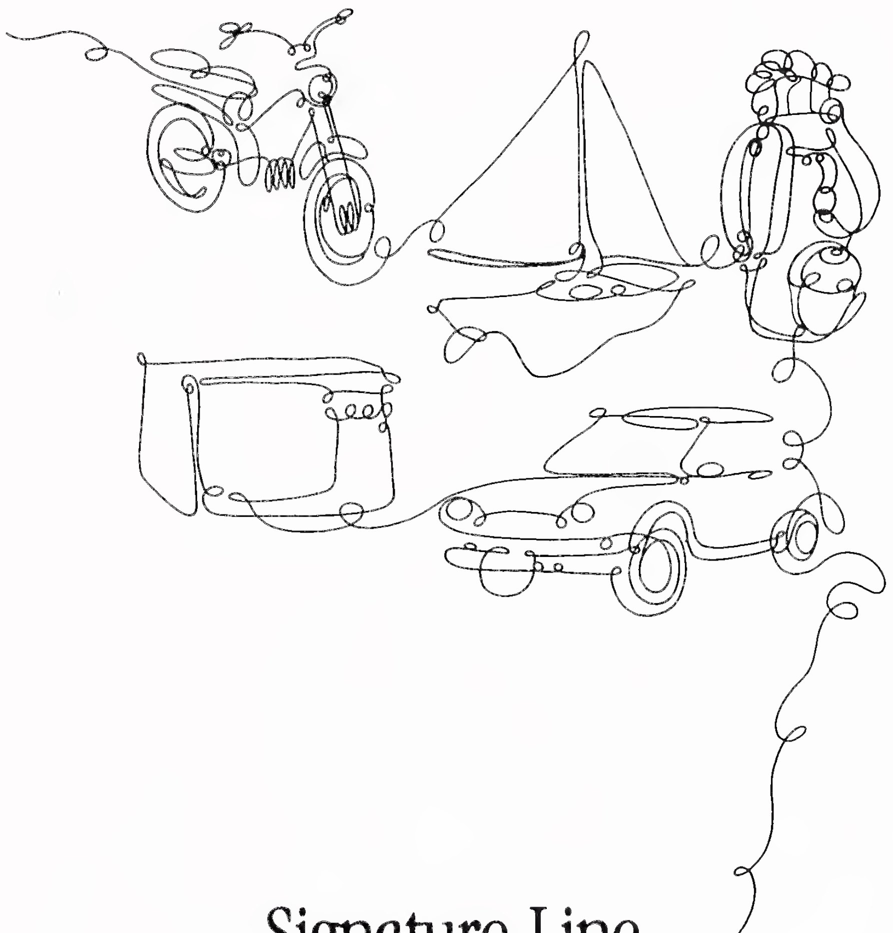


Save these monuments. Send your personal tax deductible donation to: P.O. Box 1986, New York, N.Y. 10018. **The Statue of Liberty-Ellis Island Foundation, Inc.**

STATUE OF LIBERTY—ELLIS ISLAND CENTENNIAL CAMPAIGN
BUSINESS PRESS AD NO. SOL-1603-83—7" × 10" (110 Screen)
Volunteer Agency: Kenyon & Eckhardt, Inc. Volunteer Coordinator: Sharon E. Baum, Chemical Bank

BP-SPEC
1983

The shortest distance
between you
and your credit needs:



Signature Line

We'll lay it on the line: you file one credit application. You draw from one line of credit. You use it for anything you want. You make one payment every month or every quarter. It's just what a person of your means needs–and deserves.

We'll lay our rate on the line, too: When your balance is $1,000 or more, you'll pay 2% above prime*. That's lower than most other forms of credit. And no matter how high the prime goes, you won't pay more than 18% APR.

Let's face it. You don't need the bother of completing an application every time you want credit. Don't. Choose the shortest distance between you and your credit needs: Signature Line.

Phone 1-800-632-4453 during normal business hours.

Call Union Bank, toll-free, for a Signature Line brochure and application.

*Signature Line interest rates are based on Union Bank's prime rate. The Annual Percentage Rate may vary from 11.5% to 18% if your average daily balance is over $1,000. If your average daily balance is $1,000 or less, the Annual Percentage Rate (APR) is 18%.

UB UNION BANK
Member FDIC

Auxiliary sponsors Organ Donor Week April 22-28

By Dorothy Csonka

April brings the culmination of months of work by the Michigan State Medical Society Auxiliary in preparation for the second *Organ Donation Awareness Week,* April 22-28. The week's campaign is being led by the MSMS Auxiliary and the Organ Procurement Agency of Michigan, The Michigan Eye Bank, the Kidney Foundation of Michigan, and the National Institute for Burn Medicine. The purpose of the campaign is to encourage the use of the organ donation label designed for use on the reverse side of driver's licenses.

The MSMS Auxiliary has requested a governor's proclamation and resolutions from the House and Senate. An attractive new brochure has been printed and will be distributed by the agencies and county auxiliaries. Churches and synagogues in southeastern Michigan have been asked to include a special flyer in weekly bulletins. County auxiliaries have been requested to provide publicity in their local press, radio, and TV.

In keeping with our "Year of the Child" theme, the auxiliary has purchased a movie on the subject of fetal alcohol syndrome, "One For My Baby." We have begun circulating it to the counties. Oakland County Auxilians are participating in training sessions for presenting this movie in their schools, and will serve as a model group for other counties.

The subject of child abuse prevention is being introduced to auxilians through the use of a special package program developed by our national organization. Numerous projects are offered as examples which can be tailored for local needs, alone or in cooperation with other organizations.

Several members of the Auxiliary will assist the *Michigan Committee For The Prevention Of Child Abuse* at a live drama production of "Bubbylonian Encounter." This excellent teaching tool on the subject of sexual abuse prevention is targeted for young children. Auxilians attended this play March 6 at the Boarshead Theatre — Center For The Arts in downtown Lansing. A panel discussion following the production provided information on how this program can be introduced to community schools.

Ms. Csonka, of Essexville, is health projects chairperson for MSMS/A.

Your FREE HCN Coffee Cup!

TAKE A BREAK EACH WEDNESDAY

with **Health Care News**, the most accurate, reliable, and complete way to keep abreast of health care regulations, legislation, mergers, moves, negotiations, people, continuing education, and job opportunities. We give you the news you need to know **52 times a year for only $11. $20 for 2 years & a free coffee cup.**

Health Care News

SERVING MICHIGAN'S HEALTH CARE PROFESSIONALS

Subscribe now. Limited time only.

☐ Payment Enclosed
☐ New
☐ Renewal
☐ Bill me— $1.50 additional
☐ Bill firm—$1.50 additional
☐ Visa ☐ Mastercard

Firm Name (if applicable)__________
Name __________
Address__________
City/State/Zip __________
Interbank #__________ Exp. Date __________
Signature__________
Drivers License Number __________

5440 Cass Avenue • Detroit, Michigan 48202 • (Phone (313) 831-3323
Telephone Orders Accepted

Medical Data Services - Texas Instruments

Working Together To Make Your Practice $UCCESSFUL

MDS, the nation's leading specialist in the business management of **MEDICAL PRACTICES**, has joined with **TEXAS INSTRUMENTS**, the leader in sophisticated computer systems, to provide private physicians with a state-of-the-art, user-friendly, low cost medical billing-accounts receivable management system.

To be more $uccessful **CALL TODAY** for a no-obligation proposal for your practice.

Toll Free in Michigan 1-800-482-6972

TEXAS INSTRUMENTS
COMPUTER SYSTEMS

MEDICAL
DATA
SERVICES

5420 HILL-23 DRIVE
FLINT, MICHIGAN 48507

1-800-482-6972 **313-238-1666**

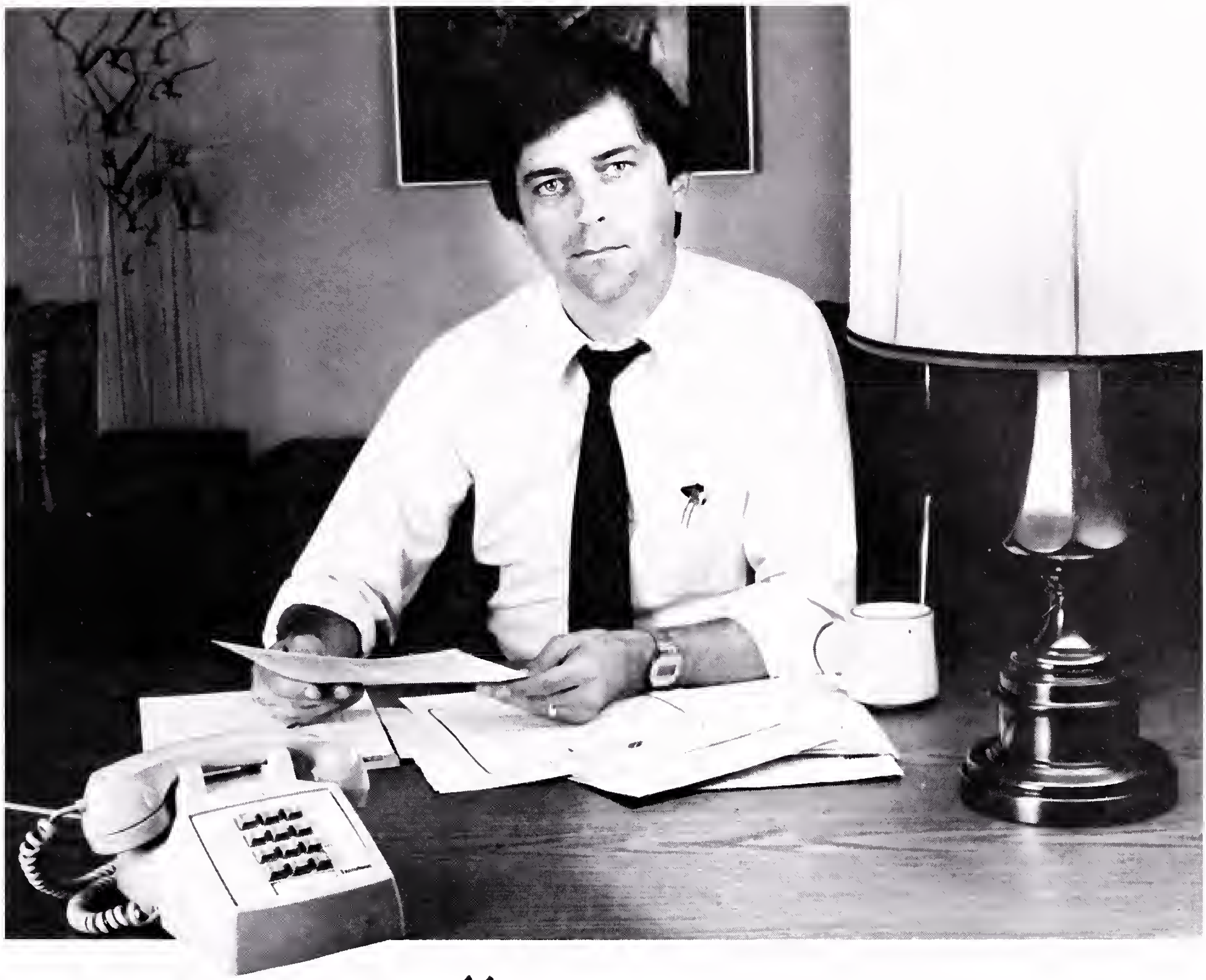
Medical Data Services is a subsidiary of Charter Medical Corp.

By Joyce Crum

In 1983, for the sixth consecutive year, Michigan gained AMA members. The state added nearly 600 total members, half of them medical students taking advantage of a year's free membership offer. Another large gain was in resident members. To recognize the state's membership growth, AMA President Frank J. Jirka, MD, Barrington Hills, IL, right, presented a membership award to MSMS President Donald K. Crandall, MD, Muskegon. The occasion was the 1984 AMA Leadership Conference in Chicago.

Joseph J. Weiss, MD, Livonia, is one of the runners-up of the 1983 *Medical Economics* contest for best original articles by physicians. His winning article, "The fringe benefit that makes my staff work hardest," was published December 26, 1983. He has his choice of a weekend for two in New York City, New Orleans, or San Francisco. **Kirk Laman, MD,** Inkster, received an honorable mention in the competition ... Five MSMS members are new appointees to committees of the American Academy of Family Physicians: **George A. Dean, MD,** Southfield, Committee on Cancer; **Douglass A. Haddock, MD,** Kalamazoo, representative to Residency Review Committee for Family Practice; **Harold F. Kendrick, MD,** Pontiac, Committee on Mental Health; **Gary E. Ruoff, MD,** Kalamazoo, Ad Hoc Task Force to Study the Future of AAFP Involvement in Family Practice Education, and **Robert L. Vitu, MD,** Saginaw, Committee on Hospitals ... **Charles H. Wright, MD,** Detroit, is recipient of the Lifetime Achievement Award from Wayne State University's Phylon Society. Doctor Wright was recognized for founding the Afro-American Museum in Detroit ... **Phillip R. Glotfelty, MD,** Marshall, is new president of the Calhoun County Medical Society. He is past chief of staff at Oaklawn Hospital. Named president-elect is **Charles L. Seifert, MD,** Battle Creek ... **St. Clair County Medical Society** has received the first annual Community Service Award of Yale Center for Human Resources. The award, for outstanding contributions to human services in St. Clair County, was presented in recognition of the free medical care program recently initiated by the Society ... **Frank Bunker, MD,** Benton Harbor cardiologist, is new Berrien County Medical Society president. President-elect is **Gideon Medina, MD,** Niles ... Newly elected as president of the Delegate Assembly of the American Heart Association of Michigan is **Thomas Miyata, MD,** St. Joseph ... As of September 1, **Daniel S. Mazzuchi, MD,** will be dividing his time between Marquette and East Lansing, when he will assume the position of associate dean for community programs at Michigan State University College of Human Medicine. He will be in charge of MSU's medical programs in six areas in the state. Since 1977 he has been an assistant MSU dean and vice president of the Upper Peninsula Medical Education Corporation. He will be in full-time residence in East Lansing beginning January 1, 1985 ... **Willys F. Mueller, Jr., MD,** Fenton, is new president of the Michigan Society of Pathologists. Doctor Mueller is the pathology director for Hurley Medical Center ... Hurley Medical Center's burn unit has been named for **Franklin V. Wade, MD,** Flint, in recognition of his 33 years of service to Hurley Medical Center and the greater Flint community ... **Busharat Ahmad, MD,** Marquette, is 1984 president of the Eye Bank Association of America. Doctor Ahmad is an MSMS district director and chairman of the MSMS Committee on Publications ... **Douglass A. Haddock, MD,** Kalamazoo, has been re-elected to the Council of Medical Specialty Societies Board of Directors. He has served on the board since 1982 ... Michigan Psychiatric Society's new president is **Melvin Bornstein MD,** Birmingham ... **Erwin E. Grasman, MD,** Muskegon, is the new president of the Muskegon County Medical Society. **Richard T. Wilcox, MD,** Muskegon, is the new president-elect. ...

Ms. Crum is secretary to *Michigan Medicine.*



“...Your financial security specialist is on call”

American Physicians Life believes a physician’s financial security deserves specialized attention. That’s why our products and services are designed with the doctor in mind. Our comprehensive portfolio of services, including life insurance, professional disability income coverage, qualified plans and tax-deferred annuities, is customized to meet your personal financial planning needs as well as those of your professional corporation.

Let American Physicians Life secure your financial planning program—that’s our specialty!

Call today for the financial security specialist in your area.

AMERICAN PHYSICIANS LIFE
Bates Drive, P.O. Box 281
Pickerington, Ohio 43147
Telephone (614) 864-3900
Toll-free in Ohio, 1-800-282-7515
Toll-free outside Ohio, 1-800-742-1275

Reye's Syndrome

Three Michigan children with Reye's Syndrome were reported to the Michigan Department of Public Health between February 18 and March 2. Two are school-aged children; one is a one-year-old. RS was preceded by upper respiratory infection in all three. One of the children was admitted to hospital at Stage II; the other two were admitted at Stage I. The total number of RS cases in Michigan since October 1, 1983 stands at 13 with one death.

Although no additional school-based outbreaks of influenza-like illness were reported in the past two weeks, the MDPH continued to receive reports of influenza virus activity in Michigan through the end of February. All influenza virus isolates obtained by the MDPH virology laboratories since the last update memo have been type A (H1N1) England-like.

In the Great Lakes Region, the following states have reported RS cases since October 1, 1983:

Illinois	4
Indiana	1
Minnesota	4
Ohio	6
Ontario	0
Wisconsin	3

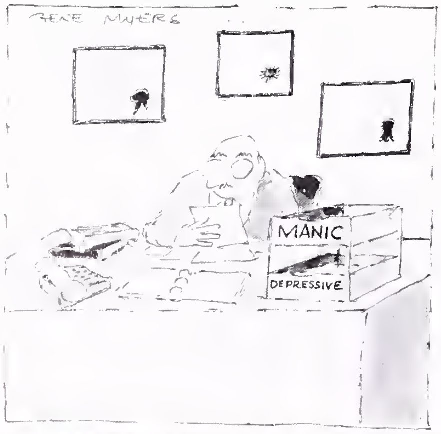
Health promotion

Six facilities have been chosen by the Kellogg Foundation of Battle Creek to take part in a comprehensive project to help Michigan hospitals better serve the health needs of local residents. They are Lansing General Hospital; Borgess Medical Center, Kalamazoo; Holland Community, Zeeland Community and Allegan General hospitals, considered together as one site; Helen Newberry Joy Hospital, Newberry; University of Michigan Hospital's Turner Geriatric Clinic, and Hills and Dales Community Hospital, Cass City.

The hospitals have grants to demonstrate a community health promotion program being spearheaded by the Hospital Research and Educational Reserve of Michigan, Inc. (HRER), of Lansing.

An earlier award of $776,100 was made to HRER, the research and educational arm of the Michigan Hospital Association, to serve as a catalyst and facilitator of community health promotion demonstrations. A provision was made by the Kellogg Foundation to award a total of $500,000 in equal-matching grants to hospitals to pilot test such programs.

"In response to a national trend which focuses on good health, hospitals are answering with diverse health promotion programs tailored to fit community needs," explained Sherry Mirasola, health education coordinator with the Michigan Hospital Association. "The Michigan pilot sites will be addressing a variety of risk factors in their perspective service areas. The implementation of these ambitious projects, combined with other ongoing hospital programs, will greatly enhance the quality of life for Michigan residents."



Marijuana use down

University of Michigan researchers report use of marijuana and other illicit drugs by American high school seniors continued to decline in 1983.

In a report released by the National Institute on Drug Abuse, the federal agency sponsoring the research, social psychologists Lloyd Johnston, Patrick O'Malley and Jerald Bachman of the U-M Institute for Social Research (ISR) state that the overall decline is "an encouraging sign that the downturn, which began in the past couple of years, is real and continuing."

The investigators caution that while use of certain drugs has shown a rather dramatic decline, the proportion of high school seniors who have had some illicit drug experience has not yet dropped a great deal.

But, they say, the proportion of high school seniors who used marijuana during the year prior to the survey dropped from a high of 51 percent in 1979 to 42 percent in 1983.

And more importantly, daily use of marijuana (20 or more occasions in the month preceding the survey) has fallen by one-half — from 10.7 percent in 1978 to 5.5 percent in 1983, the lowest level since the study began in 1975.

Glaucoma treatment

Sinai Hospital of Detroit is one of seven centers participating in a National Eye Institute sponsored study to determine if laser therapy or topical medication is the best primary treatment for primary open angle glaucoma. Hugh Beckman, MD, chairman of the Department of Ophthalmology at Sinai Hospital of Detroit, will direct the Detroit activity.

"The purpose of this study is to determine under controlled conditions which method, laser or medicine, for reducing intraocular pressure in newly diagnosed open-angle glaucoma is the more effective and safe therapy," Doctor Beckman says.

Besides Sinai Hospital of Detroit, other participating study centers are: Albany Medical College, Massachusetts Eye and Ear Infirmary, New York Eye and Ear Infirmary, University of Arizona, University of Illinois and Wills Eye Hospital, Philadelphia. Johns Hopkins University School of Hygiene and Public Health will coordinate data.

The study is being supported by grants from the National Eye Institute.

Fetal Alcohol Syndrome

The National Clearinghouse for Alcohol Information (NCALI) is currently conducting an intensive outreach effort to state and national health care organizations with regard to women's alcohol use during pregnancy. We offer the Fetal Alcohol Syndrome Package for Healthcare Providers (SP2400) and the FAS prevention article for medical educators.

Included in the package is a booklet on diagnosing alcohol abuse among women, an excerpt from a *Journal of the American Medical Association* article on fetal alcohol effects and their potential etiological mechanisms, and an order form listing additional FAS/FAE resources. The article for medical educators discusses opportunities for incorporating FAS prevention information into medical education training.

These materials all are available from NCALI, the information dissemination branch of the National Institute on Alcohol Abuse and Alcoholism (NIAAA). Physicians also may be interested in our other alcohol-related materials concerning women and alcohol use and our Health Professions Education (HPE) Project. The HPE Project seeks to promote the education of health professionals in alcohol abuse prevention, diagnosis, and treatment.

Prevention of fetal alcohol effects is an important issue of mutual concern. MSMS members can play a key role in the clinical care process. By working together at both the state and national levels, the potential for FAS prevention is greaty increased.

For materials and information, our address is: National Clearinghouse for Alcohol Information, Station MI, PO Box 2345, Rockville, MD 20852. The telephone number is (301) 468-2600.

Wayne State University School of Medicine Alumni Association 116th Medical Alumni Reunion Day

Saturday, May 12, 1984
Michigan Inn Hotel
Southfield

CLINICAL PROGRAM

$25 — WSU Medical Alumni Association members
$50 — Non-members
9 a.m. — 4:30 p.m.
Topic: "WSU Advances in Medicine 1984"
6 hours CME credit
Sessions will include:
- Present and Future Direction of the Medical School
- Critical Care: Update 1984
- Modern Concepts of Mucosal Immunology
- Monoclonal Antibodies
- Hypertensive Renal Angiography in Retrospect and Prospect
- Alcohol and Its Effects on the Fetus
- Can Chemotherapy Eliminate Need for Surgery?
- Breast Cancer: Options, Opinions and Data

LUNCH:

Compliments of WSU Medical Alumni Association
Presentation of student awards
Annual Business Meeting

EVENING PROGRAM

Michigan Inn Hotel
7 p.m. to Midnight
$65 — couple
$32.50 — single
Presentation of Distinguished Alumnus Award,
Lawrence M. Weiner Award
Silver and Gold Anniversary Certificates
Dinner, dancing, class reunions

For further information, call
WSU School of Medicine, (313) 577-1495

MSMS, MSMS/A, AMA, and medical assistants

April 22-28 — Second Annual Organ Donation Awareness Week in Michigan, sponsored by Michigan State Medical Society Auxiliary, Michigan Eye Bank, National Kidney Foundation of Michigan, Organ Procurement Agency of Michigan and National Institute for Burn Medicine, contact: Dorothy Csonka, 14 Sovey Court, Essexville.

April 26-29 — Annual convention, American Association of Medical Assistants, Michigan State Society, Lansing Hilton Inn, contact: Meridee Gerger, CMA-AC, at 517/485-2130.

April 30 — Michigan State Medical Society Auxiliary special Leadership Day, contact: Vi Heins, MSMS headquarters, East Lansing.

May 4-6 — MSMS House of Delegates Meeting, Amway Grand Plaza Hotel, Grand Rapids, contact: Warren Tryloff, MSMS headquarters.

May 14-16 — Michigan State Medical Society Auxiliary 58th Annual Session, The Troy Hilton, Troy, contact: Vi Heins, MSMS headquarters, East Lansing.

May 23 — AMPAC/MDPAC State Political Education Seminar, at MSMS headquarters, contact: Kevin Kelly, MSMS headquarters.

July 26-29 — Midsummer Meeting, MSMS Board of Directors, Deer Lake, Boyne Mountain, contact: Warren F. Tryloff, MSMS headquarters.

Sept. 19 — MSMS Board of Directors meeting, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Nov. 21 — MSMS Board of Directors meeting, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Other meetings

April 27 — "Empathic Listening: A Program for Clergy and Those Involved in Care for the Dying," Lansing General Hospital. Contact: Healthtrak (517) 377-8419.

April 28-29 — 29th Scientific Session of Michigan Society of Anesthesiologists, Sheraton Southfield, contact: Caroline Rich, MSMS headquarters, East Lansing.

May 18-19 — Conservative Treatment of Low Back Pain, Jackson, sponsored by Camp International, Inc., contact: Isabelle S. Green, Medical Informatics Manager, Camp International, Inc., Box 89, Jackson 49204.

May 19 — Michigan Society of Pathologists, business/scientific sessions, Dearborn Inn, Dearborn, contact: Vi Heins, MSMS headquarters, East Lansing.

May 19-26 — Michigan Week, contact: Sharlan Douglas, Greater Michigan Foundation, (313) 963-3396.

May 31-June 1-3 — Michigan Association for Medical Education Annual Meeting, Point West, Macatawa, contact: Vi Heins, MSMS headquarters, East Lansing.

June 7-9 — American Hospital Association 7th Annual Trustee Forum, Chicago. For program information, contact: B. Olsen, AHA, (312) 280-6301; for registration, contact: Division of Education (312) 280-6083.

Calling Doctor Dwinelle . . .
you're wanted in surgery . . . !

June 14-15 — Michigan Chapter, American College of Surgeons Annual Meeting: Day 1, Resident Surgeons Day Competition; Day 2, Scientific Meetings. Grand Traverse Resort, Grand Traverse Village, contact: Viola M. Heins (517) 337-1351.

June 23-27 — Michigan Environmental Health Associations Annual Educational Conference. The Amway Grand Plaza, Grand Rapids, contact: William E. DeHann, Michigan Environmental Health Association, (616) 774-3089.

June 24-27 — National Environmental Health Association's Annual Educational Conference, Grand Rapids, contact: NEHA, 1200 Lincoln, #704, Denver, CO 80203 (313) 861-9090.

July 8-10 — Bi-annual meeting Michigan Academy of Plastic Surgery, Mackinaw Island for Plastic Surgeons, contact: Joseph Mark, MD, Michigan Academy of Plastic Surgeons, 1900 Wealthy Street, SE, Grand Rapids 49506

July 19-22 — Macula Disease, Mackinaw Island, sponsored by Michigan Ophthalmological Society, contact: Leslie E. Meissner, MOS Administrator, 29927 W. Six Mile Rd. Livonia 48152.

July 23-25 — 38th Annual Scientific Assembly, Traverse City, sponsored by Michigan Academy of Family Physicians, for Family Physicians, contact: Dru Love, Executive Secretary, Michigan Academy of Family Physicians, 109 E. Oakland, Lansing 48906.

August 9-12 — Michigan Psychiatric Society Scientific Meeting, Grand Traverse Resort, contact: MPS (313) 552-8666.

October 11-14 — ACP/MSIM Annual Regional Scientific Meeting, Boyne Highlands Resort, Harbor Springs, sponsored by Michigan Chapter, American College of Physicians in association with Michigan Society of Internal Medicine, contact: Arnold R. Axelrod, MD, FACP, Department of Medicine, Sinai Hospital of Detroit, 6767 West Outer Drive, Detroit 48235 (517) 493-5780.

Digest of Proceedings, Michigan Board of Medicine

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are summarized below by MSMS legal counsel from official memoranda to MSMS.

Doctor Involved: Matthew M. Gangwer, MD
Complaint: For suspension of license due to possession of quantities of valium.
Facts: Respondent in automobile accident in 1982 while in possession of three bottles of valium, accounting for 65 out of 90 prescribed capsules.
Decision: Consent Order, December 14, 1983, revoking limited license for post-graduate training because of drug abuse.
Dated: February 23, 1984

Doctor Involved: Sidney E. Smith, MD
Complaint: Failure to conform to minimal standards and prevailing medical practice.
Facts: Performing abdominal surgery, failure to remove a 6.5 inch hemostat. On subsequent x-ray discovery, failed to notify patient for nine months re the hemostat.
Decision: Consent Order: reprimand; license limited to prohibit surgical procedures under general or local anesthesia. November 15, 1983.
Dated: February 23, 1984

Doctor Involved: Carol R. D. Varner, MD
Complaint: Departure from standards of care with respect to medical history, clinical examinations and prescription of inappropriate medicines.
Facts: Over a two and one-half day period, respondent failed to recognize extreme diabetic ketoacidosis; patient died despite efforts of other physicians. Wholly inadequate history taken by respondent did not include any questioning or any subsequent tests leading to analysis of diabetic ketoacidosis or any diabetic condition. Inadequate history, no urinalysis taken, tardy hospitalization and probably inappropriate prescription of drugs. Lengthy opinion by ALJ.
Decision: April 22, 1982, license suspended. September 11, 1982, licensed revoked. November 12, 1983, final order: license revoked; revocation not to run concurrently with the two prior orders but new license revocation as of November 12, 1983.
Comments: Involved hearing and lengthy opinion by Administrative Law Judge.
Dated: February 24, 1984

IBM
From $4,880

The Professional Computer

MEDICAL OFFICE MANAGER

IBM/PC or XT Computers, with Management Software Options for:

- Patient Accounting
- Insurance Forms/Claims
- Appointment Scheduling
- Receivables & Payables
- Treatment/Lab Analysis
- Medical Records & Histories
- Productivity Summary
- Word-Text Processing
- Network Communications

IMPROVED:

Efficiency — Cash Flow — Profitability

— System Support, Leasing & Expansion Options —

Computer Systems 313/779-8700
26401 Harper — St. Clair Shores, MI 48081

Professional Practice Sales, Inc.

May Have the Perfect Practice For You!

Our guidance and expertise will be at your service whether you are starting out, expanding or ready to sell.

Looking for that ideal location? Consider these available areas:

- Ann Arbor — OB/GYN — Condo ownership
- Jackson — $4,250,000 — 4 locations (Send for Brochure)
- Northland — Starter Practice
- Bloomfield Hills — Dermatology
- Saratoga Hospital Area — 70 patients a day
- Redford/Plymouth Rd. area — Good location

Professional Practice Sales, Inc.
Caters Exclusively to the Health Care Profession.

27208 Southfield Road
Lathrup Village, MI 48076
(313) 569-7336

CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, (517) 337-1351.

Date: April 16-20, Spring Family Practice Review Course. Location: Towsley Center, Ann Arbor. **Sponsor:** Office of CME, U-M Medical School. **Contact:** Office of CME, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 35 hours of Category I Credit.

Date: April 18, Controversial Infections Diseases. Location: Henry Ford Hospital, Education & Research Bldg. **Sponsor:** Henry Ford Hospital Medical Education Office. **Contact:** Henry Ford Hospital, Medical Education Office, 2799 W. Grand Blvd., Detroit 48202, (313) 876-3073. **Approved for:** 6.25 hours of Category I Credit.

Date: April 18, Institutional Care and Individual Treatment. Location: Gilmore Health Education Center, Bronson Methodist Hospital, 252 E. Lovell, Kalamazoo 49007. **Sponsor:** Kalamazoo Area Council for the Humanities and Southwestern Michigan Area Health Education Center. **Contact:** Carol Fites, Kalamazoo Area Council for the Humanities, Kalamazoo College, Kalamazoo 49007, (616) 383-8430. **Approved for:** 2 hours of Category I Credit.

Date: April 19, Fifth Annual Bronson Nephrology Conference. Location: Gilmore Health Education Center, Bronson Methodist Hospital, Kalamazoo. **Sponsor:** Bronson Nephrology and Southwestern Michigan Area Health Education Center. **Cost:** In Advance: $70; Day of Registration: $80. **Contact:** Charles L. Zeller, Jr., MD, director, Continuing Medical Education, SMAHEC, Stryker Center, 4th Floor, 1521 Gull Rd., Kalamazoo 49007, (616) 388-7881. **Approved for:** 7 hours of Category I Credit.

Date: April 24, Infectious Diseases Symposium. Location: East Auditorium at Butterworth Hospital, Grand Rapids. **Sponsor:** Butterworth Hospital. **Contact:** Celia M. Steele, Conference Coordinator, (616) 774-1835. **Approved for:** 8 hours of Category I Credit.

Date: April 25-26, What's New and Practical in Critical Care. Location: Michigan Inn, Southfield. **Sponsors:** Michigan Committee on Trauma, ACS; WSU School of Medicine; Michigan Society of Critical Care Medicine. **Contact:** Theresa School, WSU Department of Surgery, 6-C UHC, 4201 St. Antoine, Detroit 48201 (313) 577-5009. **Approved for:** 12 hours of Category I Credit.

Date: April 25-26, The Carotid and The Eye. Location: Pontchartrain Hotel, Detroit. **Sponsor:** Harper-Grace Hospitals, Kresge Eye Institute, WSU Department of Surgery and Ophthalmology. **For:** Ophthalmologists, neurologists, vascular and neurological surgeons. **Contact:** WSU School of Medicine, Division of CME, 4H, UHC, 4201 St. Antoine, Detroit 48201 (313) 577-1180. **Approved for:** 9.5 hours of Category I Credit.

Date: May 2, Medical versus Surgical Management of Arterial Problems: A Common Sense Approach. Location: Gilmore Health Education Center, Bronson Methodist Hospital, 252 E. Lovell, Kalamazoo. **Sponsor:** Regional Vascular Surgery, PC, and Southwestern Michigan Area Health Education Center. **Cost:** $80.00. **Contact:** Charles L. Zeller, MD, Director, Continuing Medical Education, SMAHEC, 1521 Gull Road, Stryker Center, Kalamazoo 49001, (616) 388-7881. **Approved for:** 6 hours of Category I Credit.

Date: Beginning May 3, for five sessions at 8:00-9:30 pm, Child Sexual Abuse: Child Psychoanalytic Theory and Practice in the Diagnosis and Treatment of Sexually Abused Children. Location: Ann Arbor. **Sponsor:** Michigan Psychoanalytic Institute. **Contact:** Michigan Psychoanalytic Institute, Extension Division, 16310 W. 12 Mile Road, Suite 204, Southfield 48076. **Approved for:** 15 hours of Category I Credit.

May 4, Eighth Annual Cardiac Rehabilitation & Exercise Testing Symposium. Location: Borgess Auditorium, Borgess Medical Center, 1521 Gull Road, Kalamazoo, 49001. **Sponsor:** Borgess Medical Center & Southwestern Michigan Area Health Education Center. **For:** All physicians. **Cost:** $75.00. **Contact:** Jeffry Morgan, Cardiac Rehabilitation Institute, Borgess Medical Center, 1521 Gull Road, Kalamazoo 49001, (616) 383-8342. **Approved for:** 7 hours of Category I Credit.

Date: May 5-9, Advanced Muscle Energy Tutorial (below diaphragm). Location: Kellogg Center for Continuing Education, East Lansing. **Sponsors:** Michigan State University College of Osteopathic Medicine and College of Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

Date: May 10, Spring Clinical Conference on Gastroenterology. Location: Gilmore Health Education Center, Bronson Methodist Hospital, 252 E. Lovell, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Education Center. **Cost:** In advance: $60.00; At the door: $70. **Contact:** Charles L. Zeller, MD, Director, Continuing Medical Education, SMAHEC, 1521 Gull Road, Kalamazoo 49001, (616) 388-7881. **Approved for:** 6 hours of Category I Credit.

Date: May 11, Regional Associates Meeting, American College of Physicians. Location: Sheraton Oaks Hotel, Novi. **Sponsor:** American College of Physicians. **Contact:** Arnold R. Axelrod, FACP, Sinai Hospital, 6767 W. Outer Drive, Detroit 48235. **Approved for:** 4 hours of Category I Credit.

Date: May 14-18, Advances in Internal Medicine. Location: Towsley Center, Ann Arbor. **Sponsor:** Office of CME, U-M Medical School. **Contact:** Office of CME, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 34 hours of Category I Credit.

Date: May 17, Perinatal Horizons. Location: Western Michigan University, Kalamazoo. **Sponsor:** Southwestern Michigan Perinatal Association. **Contact:** Marilyn Potgiesser, RN, Educational Services Instructor, Bronson Methodist Hospital, 252 East Lovell Street, Kalamazoo 49007 (616) 383-6405. **Approved for:** 6 hours of Category I Credit.

Date: May 18-19, Conservative Treatment of Low Back Pain. Location: Jackson. **Sponsor:** Camp International, Inc. **Contact:** Isabelle S. Green, Medical Informatics Manager, Box 89, Jackson 49204. **Approved for:** 16 hours of Category I Credit.

Date: May 18-19, 27th Annual Clinic Days: Transfusion and Infusion Therapy in Pediatrics — Current Concepts. Location: Children's Hospital of Michigan, Detroit. **Sponsor:** CME Department, Children's Hospital of Michigan. **Contact:** CME Department, Children's Hospital of Michigan, 3901 Beaubien Blvd., Detroit 48201 (313) 494-5455. **Approved for:** 10 hours of Category I Credit.

Date: May 19-20, Gynecologic Pathology — May 19; Genitourinary Pathology — May 20. Location: Dearborn Inn. **Sponsor:** Michigan Society of Pathologists. **Contact:** Dr. Kenneth McClatchey, Department of Pathology, University of Michigan Hospital, Ann Arbor, 48109. **Approved for:** 3 hours of Category I Credit.

Date: June 11-15, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsors:** MSU Colleges of Osteopathic Medicine and Human Medicine, and the North American Academy of Manipulative Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

Date: June 13, Update on Geriatrics — 1984. Location: St. John Hospital, Detroit. **Sponsor:** Family Medical Center, Detroit. **Contact:** Judy Danbert (313) 343-3877. **Approved for:** 7 hours of Category I Credit.

Continued on page 218

Doctor . . . examine your front office . . . You'll discover you need to computerize

MEDPAC is the cure

The System That Provides:

- Patient statements, recalls, receipts, reports and aged accounts receivables
- Insurance billings, forms, reports, and BC/BS paperless claims
- Installed by computer professionals who have worked in medical offices

**Systems Starting As Low As $12,500.00
on the IBM PC, TELEVIDEO and EAGLE.**

In addition to MEDPAC's standard features, if you place an order during March and April and present this ad, MEDPAC will provide access to GTE TELENET MEDICAL INFORMATION NETWORK (Subscription fee and one year minimum monthly usage charges). TELENET is provided through Physician Service Group, Inc., (Wholly owned subsidiary of the Michigan State Medical Society).

Send the coupon below, or phone us for information:

MEDPAC
Computer Methods Corp.
13740 Merriman Road
Livonia, Michigan 48150
313-522-5187

Dr. ____________________
Address ____________________
City __________ **State** ______ **Zip** ______
Phone ____________________

George T. Aitken, MD
Grand Rapids

George T. Aitken, MD, Grand Rapids, died on January 31, 1984 at the age of 74. He was the former chief of staff at St. Mary's Hospital. Doctor Aitken was a graduate of the University of Indiana Medical School. In 1947 he helped create the Area Child Amputee Center, the first of its kind in the United States.

Morton P. Bates, MD
Kalamazoo

Morton P. Bates, MD, Kalamazoo, died on February 5. He was 76. Doctor Bates was a graduate of the Wayne State University School of Medicine. He served at Hillsdale Community Health Center in various capacities including chief of staff before joining the staff at MSU Health Center.

Ralph A. Clark, MD
Ludington

Ralph A. Clark, MD, Ludington, died on January 19. He was 55. Doctor Clark was currently the anesthesiologist at Memorial Hospital. He was a graduate of the University of Michigan Medical School.

Michael E. Ellis, MD
Grand Rapids

Michael E. Ellis, MD, Grand Rapids, died on January 20 at the age of 65. Doctor Ellis was an active member in the practice of internal medicine in the Grand Rapids area since 1949. He was a 1943 graduate of the University of Michigan Medical School.

Enid Fillingham, MD
Muskegon

Enid Fillingham, MD, Muskegon, died on January 1. She was 83. Doctor Fillingham was affiliated with Hackley and Mercy Hospitals. She was a graduate of the University of Illinois Medical School.

Darrel B. Galerneau, MD
Warren

Darrel B. Galerneau, MD, Warren, died on January 18 at the age of 91. He practiced in the Warren-Center Line area for 45 years. Doctor Galerneau held fellowships in the International College of Physicians and the American College of Surgeons. He was a graduate of Northwestern University Medical School.

Fred N. Henig, MD
Detroit

Fred N. Henig, MD, Detroit, died on January 16. He was 74. Doctor Henig was a graduate of Syracuse College of Medicine. He had practiced medicine in the Detroit area since 1937.

Thomas V. Kretschmer, MD
Saginaw

Thomas V. Kretschmer, MD, Saginaw, died December 30 at the age of 65. Doctor Kretschmer was a graduate of the Marquette University Medical School. Since 1973 he had been the medical director of Central Foundry Division of General Motors.

Sandra M. Leitner, MD
Bloomfield Hills

Sandra M. Leitner, MD, Bloomfield Hills, died on January 1 at the age of 42. She was a cardiologist at Henry Ford Hospital in Detroit. Doctor Leitner was a 1966 graduate of the University of Michigan Medical School.

Barbara D. Marks, MD
Kalamazoo

Barbara D. Marks, MD, Kalamazoo, died January 15 at the age of 45. She was a graduate of the University of Miami. She served her internship at St. Mary's Hospital and her residency at Pine Rest Christian Hospital.

James M. McHugh, MD
Birmingham

James M. McHugh, MD, Birmingham, died December 23. He was 61. Doctor McHugh was the director of child psychiatry at Pontiac State Hospital from 1956 to 1958 and was an instructor of mental health at Oakland University in 1968. He served on staff at William Beaumont Hospital. Doctor McHugh graduated from Marquette University School of Medicine.

Hugo R. Saenz, MD
Lansing

Hugo R. Saenz, MD, Lansing, died on January 5 at the age of 60. Doctor Saenz opened his practice as a family doctor in Lansing in 1959. He was a graduate of the University of San Marcos, Lima, Peru. Active in many medical organizations, Doctor Saenz was twice president of the Capitol Chapter of the Michigan Academy of Family Physicians. He also was past president of the Ingham County Medical Society and served as an MSMS delegate.

Raul M. Torres, MD
Holland

Raul M. Torres, MD, Holland, died on January 26. He was 64. Doctor Torres and his wife were the first married couple to graduate from the Wayne State School of Medicine. He practiced medicine in Detroit before moving to Holland in 1976 where he was on the staffs of Holland and Zeeland Community Hospitals.

Arthur J. W. Yates, MD
Detroit

Arthur J. W. Yates, MD, Detroit, died on February 14 at the age of 65. He was a Wayne State University School of Medicine graduate. Doctor Yates was affiliated with the East Side Central and Saratoga hospitals in Detroit.

Anthony Zukowsky, MD
Detroit

Anthony Zukowsky, MD, died January 8 at the age of 79. He was one of several medical advisers to the White House during the Kennedy administration. He practiced 25 years in North Dakota before coming to Detroit in 1976. Doctor Zukowsky had retired from practice in June of 1983.

The rate for each classified advertisement in *Michigan Medicine* is 20¢ per word, with a minimum charge of $10.00. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

Positions Open

SENIOR STAFF PHYSICIAN CARDIOVASCULAR AND THORACTIC SURGERY: Function as a Senior Staff Cardiothoracic Surgeon in large hospital based multispecialty group practice. Engage in inpatient and outpatient practice. Perform full range of adult and pediatric thoracic surgery, endoscopy, and pacemaker procedures. Engage in research, participate in teaching. Special requirements: Must be capable of performing full range of adult and pediatric cardiac procedures, general thoracic surgery, endoscopy, and pacemaker procedures; experience in and current interest in laboratory and clinical investigation; must be Board Certified or eligible; Post-Doctoral Fellowship in Cardiovascular Surgery. Minimum education requirements: MD and six years of training including internship and accredited residency in cardiovascular and thoracic surgery. 45+ hours per week. $100,000 per year. Send resumes to: 7310 Woodward Avenue, Room 415, Detroit 48202, Reference No. 9384.

WELL ROUNDED G.P. to join two man practice. Port Huron area. 329-3555 or 982-5165.

WANTED: Board certified or eligible Ophthalmologist to join general ophthalmology practice in Michigan's Upper Peninsula. Reply with Curriculum Vitae to: G. Richard Keskey, MD, Mid Peninsula Eye Clinic, 2600 College Avenue, Escanaba, MI 48929.

ORTHOPAEDIST — for Occupational Medicine Department at Henry Ford Hospital-Fairlane Center, to do musculoskeletal disability evaluations and some minor treatment; no surgery; part-time position, minimum of 12 hours per week; must have knowledge of and experience with disability evaluation process; prior activity in occupational medicine not required; send curriculum vitae to: Michael E. Somand, MD, Medical Director, Henry Ford Hospital-Fairlane Center, 19401 Hubbard Drive, Dearborn, MI 48126.

GENERAL SURGEON — Active two man surgical practice located near two large urban areas is looking for an allopathic or osteopathic trained, Board Eligible or Board Certified general surgeon. Please send curriculum vitae to Surgical Specialists, P.C., 544 North Main, Lapeer, MI 48446, (313) 664-4100.

ONCOLOGIST — Mid-Michigan community seeks oncologist for service area of 70,000. Guaranteed first year income of $120,000. Office space available in medical office building adjacent to the hospital. 236 bed hospital provides major diagnostic capabilities. Excellent opportunity for a physician seeking a very busy private practice opportunity with guaranteed financial success. Submit C.V. to Box 55, Michigan Medicine, 120 W. Saginaw, East Lansing, MI 48823.

GASTROENTEROLOGIST — Mid-Michigan community seeks gastroenterologist for service area of 70,000. Guaranteed first year income of $120,000. 236 bed hospital provides major diagnostic capabilities. Excellent opportunity for a physician seeking a very busy private practice opportunity with guaranteed financial success. Submit C.V. to Box 55, Michigan Medicine, 120 W. Saginaw, East Lansing, MI 48823.

MICHIGAN: EMERGENCY CONSULTANTS, INC. currently staffs Emergency Departments throughout the state. Full-time and part-time positions available in rural and urban locations. Guaranteed hourly rate plus malpractice insurance. Contact Emergency Consultants, Inc., 2240 South Airport Road, Suite 115, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

GROUP HEALTH, INC., the midwest's largest and oldest prepaid multispecialty group, seeks associates in ALLERGY, CARDIOLOGY, FAMILY PRACTICE (no ob/gyn), GERIATRICS, and OBSTETRICS/GYNECOLOGY. Must be board certified or eligible. Excellent facilities, comprehensive benefits, highly competitive earnings. Send curriculum vitae to: Paul J. Brat, MD, Medical Director, GROUP HEALTH, INC., 2829 University Avenue Southeast, Minneapolis, Minnesota 55414.

THE GRAND RAPIDS DIVISION OF THE DETROIT INDUSTRIAL CLINIC is in need of an additional physician. Preference is for a physician with approximately 5 years practice experience and a background of family practice, surgery, internal medicine, ER, orthopedics or psychiatry. Send CV to R. R. Silver, MD, Detroit Industrial Clinic, 20755 Greenfield Road, Southfield, Michigan 48075.

PRIMARY CARE PHYSICIANS needed for multi-specialty clinic with family practice base. Need primary care general practice internists and general surgeons. Reply with CV to — Administrator, Redford Medical Center, 25210 Grand River, Detroit, MI 48240.

NEW CLINIC OPENING — Position for Family Practice or General Internist. Eight locations. Complete out-patient facilities at multiple locations. Liberal salary, full benefits and physician does his own hospital billing. Call Mary at (313) 921-8080 for appointment.

POSITIONS WITH THE STATE OF MICHIGAN — Currently taking applications for positions expected to be available in the future. Office locations now include Kalamazoo, Lansing, Southfield, and Traverse City. A board certified or board eligible psychiatrist needed for the Kalamazoo office, and internists with rheumatology or cardiology background desired for other offices. Beginning salary in low 60s with approximately 26% fringe benefits. An equal opportunity employer. All inquiries treated confidentially. For further details, please write: Harry D. Nesmith, MD, Chief Medical Consultant, Disability Determination Service, PO Box 30011, Lansing, Michigan 48909.

GENERAL INTERNISTS AND FAMILY PRACTITIONERS interested in geriatric medicine will find an optimal practice setting in our Sun City, AZ healthcare centers. CIGNA Healthplan, Inc., one of the nation's largest prepaid health plans, offers an opportunity to practice medicine free of the business aspects. Night and weekend call is very light. Competitive salaries. Excellent benefits. Please respond to: Director, Professional Recruitment, PO Box 29030, Phoenix, AZ 85038 (602) 954-3506.

FAMILY PHYSICIAN: IMMEDIATE OPENING for a residency trained FP preferring small-town life style and interested in "whole person medicine from the Christian perspective" in a new office in the small college town of Hillsdale in southern Michigan. Write or call: Frederick L. Bean, MD, Hillsdale Family Practice, 111 South Howell, Hillsdale, 49242, (517) 437-7307.

SOUTHERN CALIFORNIA — We are seeking experienced specialists and general practitioners for our facilities in Los Angeles and Orange Counties. Located in close proximity to major teaching centers, we offer the opportunity of continued professional development and rewarding clinical practice in association with 350 full time physicians. Compensation and benefits are excellent including paid vacation, educational leave, sick leave, and retirement; insurances included are malpractice, life, disability, medical and dental. Send CV to: Director/Physician Recruitment, CIGNA Healthplans of California, 700 N. Brand Blvd., Suite 500-M, Glendale, CA 91203.

Positions Wanted

ANESTHESIOLOGIST WITH EXTENSIVE training and experience of latest methods in all sub. specialties, teaching and administrative experience, licensed, Board eligible, in Anesthesia. University training — available — all areas considered. Box 56, Michigan Medicine, 120 W. Saginaw, East Lansing, MI 48823.

PATHOLOGIST, Certified Anatomic and Clinical Pathology, experienced in both and as Lab Director (Large/small hospitals, commercial labs) seeks full/part-time opportunities for professional or administrative skills in health related field. Box 54, Michigan State Medical Society, 120 W. Saginaw, E. Lansing, MI 48823.

Miscellaneous

FOR SALE: General practice in lower thumb area. Attractively priced with generous terms available. Contact: Michigan Practice Brokerage Corporation (313) 827-8874.

FAMILY PRACTICE FOR SALE: Large well established, small town in Western Oakland County. Equipped office building and reliable staff can be included. Reply P.O. Box 115, Franklin, MI 48025.

IDEAL LOCATION heavy traffic — Strip Shopping Center. $600 per month — Walled Lake, share space with Podiatrist. Dr. S. Cyril Leib, DPM, 1266 S. Commerce Road, Walled Lake, MI 48088.

FOR LEASE — IN OAKLAND COUNTY in the beautiful lakes area of Union Lake and Walled Lake. Area is growing but with a solid base of older homes. New professional buildings in what will be "the" place to go for health and dental care. A place with an "identity." Custom designed suites from 1,200 to 6,000 s.f. Ideal for specialists as they are needed in this area. A great area to live in! For more information call (313) 363-3228 or 625-0660.

Rx PADS PRINTED to your specifications. $20.00 per thousand in pads of 100. $21.00 one time set up charge. Shipping additional. Small Craft Printing Company, 211 E. Kalamazoo St., Lansing, MI 48933 (517) 485-0553.

PREVIOUSLY OWNED MEDICAL LABORATORY AND OFFICE EQUIPMENT available in excellent condition. We buy, sell, trade, move and repair. Office assessments available by certified surgical consultants. Call Doctor Medical Resale, Ltd. (313) 569-4407, 9 AM to 9 PM.

KIAWAH ISLAND, WILD DUNES BEACH and Racquet Club, Charleston, S.C. resorts. Choice 1-4 Bedroom Villas for rent. In prime locations, including ocean front. 25% owner discount. Brochure. (803) 556-6353.

FOR SALE HUNTING CLUB: Alcona County, Caledonia Township, Section 12, Consisting of 234 acres and lodge. Available for inspection any time. Approximately 5 miles from Hubbard Lake Corners on the Hubbard Lake Trail. Area with hills, swamp, deer, turkeys, bear and rabbit hunting, ski and snowmobile wintertime, very quiet. Contact Box 91, Hubbard Lake, MI 49747.

EQUIPMENT FOR SALE: Michigan League of Savings Institutions has the following equipment for sale: Xerox 3100 LDC Copier — $1,500.00, Elliott Addressograph-Model 6725 — $25.00, AB Dick Offset Duplicator-Model 326 — $1,200.00. All of the equipment has been under a maintenance agreement and can be continued by the buyer. If you are interested, please give Barb Henderson of our staff a call at 371-2200.

CLASSIFIED ADS/Continued

ONE OR TWO DOCTORS' office available for lease in Lansing, MI. Newer building, good location, and partially furnished. For further information please phone: (517) 485-4494.

WANTED USED: Olympus colonscope, Olympus Gastroscope, Olympus Light Source. Contact: Richard B. Asburt, MD, 770 Riverside Avenue, Adrian, MI 49221, phone (517) 263-7808.

SAIL BEAUTIFUL LITTLE TRAVERSE BAY — Lake Michigan Hagerman's Sailing School, Petoskey, MI. Two, three or five day courses of instruction for novices or new cruising sailors aboard a 27′ sloop $60 per person/per day. Skippered charters! Reserve preferred dates early. Write or call: 1630 Milrose, East Lansing, MI 48823 (517) 337-7009.

1984 CME CRUISE/CONFERENCES ON LEGAL-MEDICAL ISSUES — Caribbean, Mexican, Hawaiian, Alaskan, Mediterranean. 7-14 days in Winter, Spring, Summer. Approved for 18-24 CME Cat. 1 credits (AMA/PRA). Distinguished professors. FLY ROUNDTRIP FREE ON CARIBBEAN, MEXICAN & ALASKAN CRUISES. Excellent group fares on finest ships. Registration limited. Pre-scheduled in compliance with present IRS requirements. Information: International Conferences, 189 Lodge Ave., Huntington Station, N.Y. 11746. (516) 549-0869.

DOCTOR, YOU CAN'T BEAT THE QUALITY OR THE PRICE! Holter Monitor scanning service. Physician owned, trained and supervised. $35.00 for cassette reports; $45.00 for reel to reel reports; no contracts to sign. We can arrange for lease/purchase of Holter equipment. Why are you paying more and getting less? DCG Interpretation (313) 879-8860.

ATTENTION DOCTORS: We have previously owned medical, laboratory, office and x-ray equipment in excellent condition. We buy, sell, trade, move and repair. Office appraisals available by certified surgical consultants. Call Doctor Medical Resale at 313-569-4407, 9 am-9 pm.

PHYSICIANS SIGNATURE LOANS TO $50,000. Up to 7 years to repay. No repayment penalties. Prompt, courteous service. Competitive fixed rate, with no points, fees or charges of any kind. Physicians Service Association, Atlanta, GA. Toll-free (800) 241-6905.

CATEGORY I/Continued

Date: June 15-16, The Management of Medical Emergencies. Location: Grand Hotel, Mackinac Island. **Sponsor:** MSU College of Osteopathic Medicine. **For:** DOs and MDs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-9714. **Approved for:** 10 hours of Category I Credit.

Date: June 24-29, 20th Annual Northern Michigan Summer Conference: An Update on Common Clinical Concerns. Location: Hilton Shanty Creek, Bellaire. **Sponsor:** U-M Office of Continuing Medical Education. **Contact:** Office of CME, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 20 hours of Category I Credit.

Date: July 8-10, Bi-annual Meeting, Michigan Academy of Plastic Surgery. Location: Mackinac Island. **Sponsor:** Michigan Academy of Plastic Surgery. **Contact:** Joseph Mark, MD, Michigan Academy of Plastic Surgeons, 1900 Wealthy Street, SE, Grand Rapids, 49506. **Approved for:** 6 hours of Category I Credit.

Date: July 19-22, Macula Disease. Location: Mackinac Island. **Sponsor:** Michigan Ophthalmological Society. **Contact:** Leslie E. Meissner, MOS Administrator, 29927 W. Six Mile Rd., Livonia, 48152. **Approved for:** 8 hours of Category I Credit.

Date: July 23-25, 38th Annual Scientific Assembly. Location: Traverse City. **Sponsor:** Michigan Academy of Family Physicians. **Contact:** Dru Love, Executive Secretary, Michigan Academy of Family Physicians, 109 E. Oakland, Lansing, 48906. **Approved for:** 15.75 hours of Category I Credit (19-Wyeth Autotutors, 16-ACLS Course).

Date: July 26-27, Coller Penberthy Thirlby Medical Conference. Location: Park Place Hotel, Traverse City. **Sponsor:** Munson Medical Center. **For:** All interested physicians. **Contact:** Norma Powers, Coordinator of Medical Education, Munson Medical Center, 6th and Madison Streets, Traverse City 49684 (616) 922-9544. **Approved for:** 9 hours of Category I Credit.

Date: August 13-17, Tutorial on Direction Action Thrust Manipulative Therapy. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU College of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

Date: September 8-12, Fundamental of Muscle Energy. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU College of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

Date: September 10-12, Hemodynamic Monitoring. Location: Towsley Center, Ann Arbor. **Sponsor:** U-M Dept. of Pathology and Office of Continuing Medical Education. **Contact:** Office of CME, Towsley Center, Box 057, U-M Medical School, Ann Arbor, 48109, (313) 763-1400. **Approved for:** 14.5 hours of Category I Credit.

Date: September 21-23, Tutorial on Myofascial Release Technique. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 24 hours of Category I Credit.

Date: October 6-10, Advanced Muscle Energy Tutorial (Above Diaphragm). Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

Date: October 25-27, 15th Annual International Symposium on Implant Surgery for the Hand and Upper Extremity. Location: Blodgett Memorial Medical Center and Amway Grand Plaza Hotel, Grand Rapids. **Sponsor:** American Society for Surgery of the Hand. **Contact:** Alfred B. Swanson, MD, 290 Blodgett Professional Building, 1900 Wealthy Street, SE, Grand Rapids, 49506 (616) 774-7394. **Approved for:** 19 hours of Category I Credit.

Date: October 26-28, Manual Medicine Principles Applied to the Extremities. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 24 hours of Category I Credit.

Date: November 13, 14 & 15, Annual Scientific Meeting. Location: Hyatt Regency Dearborn. **Sponsor:** Michigan State Medical Society. **For:** All interested physicians. **Contact:** MSMS headquarters (517) 337-1351. **Approved for:** Maximum of 18 hours of Category I Credit.

Thanks to our advertisers

Ad Council	204
AIDS	179
AMRC	201
American Physicians Live Ins. Co.	209
Boots Pharmaceuticals	188-90
Brown Pharmaceutical Co.	175
Burroughs Wellcome	181
Camp International	185
Computer Methods Corporation	215
Computer Systems	213
Dyatron Corporation	219
GTE Telenet	193
Health Care News	206
Lab of Clinical Medicine	199
Eli Lilly & Company	169
MDPAC	199
MPMLC	182-83
MSMS Program to Assist Impaired Physicians	194
Medical Data Services	207
Medical Protective	195
PICOM	197
Phoenix Baptist Hospitals	195
Professional Practice Sales, Inc.	213
Roche Lab	IBC-BC
Roerig	170-72
SSTAF	174
Smith Kline & French Lab	187
Stratton Cheeseman	177
Union Bank & Trust	205
Upjohn Co.	203
WSU Alumni	211

DYATRON, A NATIONWIDE LEADER IN PRACTICE MANAGEMENT SYSTEMS

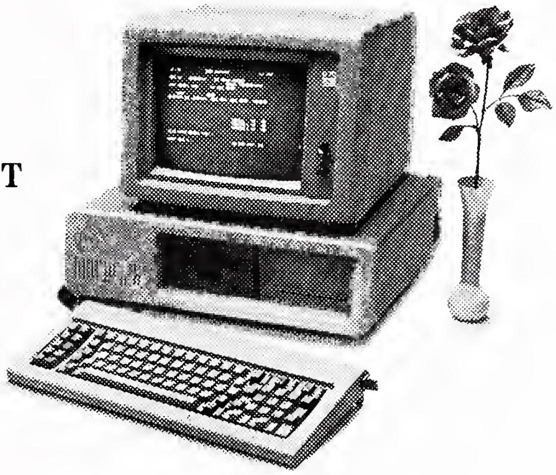
LET'S TALK ABOUT SUPPORT

The single most important component of your computer system is the software. Secondly, is your Customer Support.

Customer Support is a vital part of any computer system and is one of the key factors for a continued successful operation. After all, your reputation depends on the support you receive. In addition, your software support provides you with updates and enhancements so you may take advantage of the latest technology and improvements.

DYATRON has based their reputation on their nationally established Customer Support Network, serving over 4,000 corporate customers over the last 20 years.

To learn how DYATRON's medical services Information System, designed to run on the IBM Personal Computer XT, can enhance your practice, call Toll Free 1-800-525-2222 or contact your local representative.



IBM Personal Computer XT

DYATRON CORPORATION

Health Systems Division

VERNE M. PRIMACK, D.D.S.
Practice Consultant
Local (517) 792-8892
Corporate Headquarters:
1-800-525-2222

Special Features—

- *Modular Pricing*
- *Lifetime Software Warranty*
- *Electronic Claims Processing*
- *Permits Access to AMA Telenet*
- *Available on 10 & 20 MB Hard Disk*

Majority of physicians in future will work under contracts

Are you one of the many Michigan physicians considering providing your medical services on a contract basis?

If so, you probably are pondering, like many of your colleagues, the best time to enter into a contract, how to write such a contract, and where to go for the best advice.

I see numerous opportunities for physicians to contract for their services in the future. It is estimated that by 1990 over 40 percent of fee-for-service business will be on a contract basis. Physicians not only will work in the "fee for service" environment, but also on a contracting basis with HMOs; PPOs; hospitals, in a joint venture setting; satellite clinics and surgicenters.

Trends

The reasons for this increased interest include a shift of public policy focus from access to cost of medical care, and a shift of private policy focus from buyers to "prudent purchasers." The increasing supply of physicians has resulted in greater competition and a move from a sellers' to a buyers' market. This concern for cost has resulted in a plethora of alternative financing and delivery systems.

We have seen an increase in HMOs from 72 organizations with 4.4 million enrolees in 1973 to 280 groups with 12.3 million enrollees in 1983. Projections are that the HMO enrollment in 1993 will be around 50 million. The increased interest in PPOs in this state, as evidenced by the introduction of recent legislation, may result in a significant increase in PPO enrollment in the near future, also.

Overall, are the "megatrends" toward decentralization and a multiple option future. In this ocean of changes, we physicians are choosing a variety of business arrangements simultaneously, some more seaworthy than others. Many try the contracting.

Donald K. Crandall, MD
MSMS President

Currently 26 percent of physicians have formal arrangements with hospitals, resulting in 62 percent of their income. This trend will increase at a rapid rate, especially among younger physicians. We also will see contract arrangements for basic hospital staff privileges and for exclusive provider arrangements with hospitals.

Steps

Before physicians enter such arrangements, we must have available to us complete analyses of our current practices. We must know the demographics of our practice, as well as the practice costs, pricing strategies, product lines and target markets. We must then analyze the parties offering the contracts to see what they can offer us, and how the arrangements will affect our practices. We also must analyze the ability of the other parties to deliver their product. There are hundreds of PPOs in California which have yet to deliver a single patient to the physicians from which they're collecting enrollment fees.

Once we have a complete analysis of our practice and an analysis of the second party, the data necessary for negotiation, and a positive decision to enter into a contract; then, and only then, is it time to analyze the contract.

There are specific areas of a contract that should be looked at closely. These "sensitive" subjects include the restriction of referral, hold harmless clause, open-ended utilization review, termination clause, turn around claim time, liability insurance requirement, and arbitration clauses.

There are two books available from the AMA that will be helpful in your analysis of a contract. They are "Physician-Hospital Contracts" and "PPOs." In the end, professional help well may be needed.

Our own MSMS Section on Medical Economics and Reimbursement is ready to assist us in taking the necessary steps, reaching expert help and making good decisions. They are available by calling 517/337-1351 during the work week.

There is an interesting movement going on in Colorado with hospital medical staffs. There, staffs are incorporating to sell their services to the hospital. All physician services on the hospital committees and review functions are reimbursed to the medical staff company. This allows the medical staff to hire its own legal counsel to help in bylaws changes and contract relations with the hospitals.

It is unclear at this time how medical staff/hospital relations will evolve in the future. What is clear is that the vast majority of physicians will be working under some kind of contract arrangement in the future. Now is the time to prepare by learning the necessary contracting skills.

COMPLETE LABORATORY DOCUMENTATION[1-5]... EXTENSIVE CLINICAL PROOF

FOR THE PREDICTABILITY
CONFIRMED BY EXPERIENCE

DALMANE® (IV)

flurazepam HCl/Roche

THE COMPLETE HYPNOTIC
PROVIDES ALL THESE BENEFITS:

- Rapid sleep onset[1-6]
- More total sleep time[1-6]
- Undiminished efficacy for at least 28 consecutive nights[2-4]
- Patients usually awake rested and refreshed[7-9]
- Avoids causing early awakenings or rebound insomnia after discontinuation of therapy[2,5,10-12]

Caution patients about driving, operating hazardous machinery or drinking alcohol during therapy. Limit dose to 15 mg in elderly or debilitated patients. Contraindicated during pregnancy.

DALMANE® (IV)
flurazepam HCl/Roche

References: 1. Kales J *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol 3*:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **9.** Amrein R *et al*: *Drugs Exp Clin Res 9*(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol 3*:303-326, May 1981. **11.** Greenblatt DJ *et al*: *Sleep 5*(Suppl 1):S18-S27, 1982. **12.** Kales A *et al*: *Pharmacology 26*:121-137, 1983.

DALMANE® (IV)
flurazepam HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

DOCUMENTED IN THE SLEEP LABORATORY[1-5]...
PROVEN IN THE PATIENT'S HOME
FOR A COMPLETE NIGHT'S SLEEP
DALMANE® ⓘⓥ
flurazepam HCl/Roche
STANDS APART
15-MG/30-MG CAPSULES

See preceding page for references and summary of product information.
Copyright © 1984 by Roche Products Inc. All rights reserved.

MICHIGAN MEDICINE

May 1984 The award-winning JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Vol. 83, No. 24

STACKS
225 0000000000 123184
SERIALS DEPT - LIBRARY
COLLEGE OF PHYS OF PHILA
19 SOUTH 22ND STREET
PHILADELPHIA, PA 19103

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA
MAY 1 1984

The first decade

1953.

- General Dwight D. Eisenhower was inaugurated President of the United States; his vice president was Richard M. Nixon.
- The Korean armistice was signed to end the Korean War.
- Not one home owned an electronic calculator or color TV.
- It cost 3¢ to mail a letter.
- The Studebaker was the "new American car with the European look."
- Jacqueline Bouvier was engaged to U.S. Senator John F. Kennedy; **and**
- **the Stratton Agency began serving the Michigan State Medical Society!**

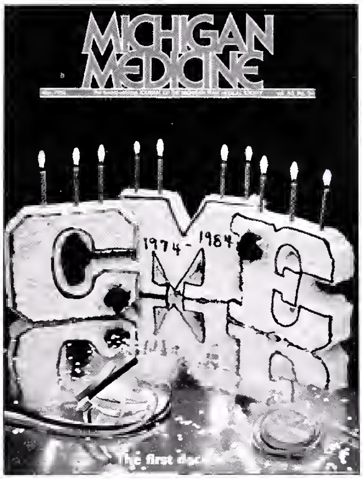
We have appreciated your participation and support over the past 30 years. If you would like additional information about our services, we would be happy to hear from you.

STRATTON-CHEESEMAN & ASSOCIATES, INC.
1305 Abbott Road, P.O. Box 1563
East Lansing, Michigan 48823

800-292-1926

May 1984, Vol. 83, No. 24

MICHIGAN MEDICINE



About the cover

The CME accreditation process in Michigan is 10 years old, as our cover illustrates. See our special report inside for details. Photo by Kim Kauffman.

Special report

224 The CME system has matured considerably since Michigan physicians first were required to take regular postgraduate training. The aim of planners and accreditors today is to link their educational offerings more closely to actual medical practice needs. Quality is the emphasis, and CME is becoming ever more essential to the correct practice of medicine. This month's special report tracks the progress of the CME system in the past 10 years, describes how the accreditation process works, and the MSMS role in the process. Would your group like to cosponsor a Category I CME course with MSMS? You'll discover the steps in this issue; Robert L. Tupper, MD, Vada L. Davis, and Sherry L. Fent

Features

229 Acquired Immune Deficiency Syndrome (AIDS): The second Category I CME quiz presented in *Michigan Medicine* by the MSMS CME Programming Committee; Evelyn J. Fisher, MD

234 Medicaid's PPSP — Is it working? Stephen Bachleda

240 Michigan physicians are becoming their own PPO experts; Judith Marr

248 Financial planning: The dynamics of municipal bonds; Katharine S. Brown

Departments

223 Letters

244 News; Joyce Crum

250 MSMS/A; Betty Drew

254 Views; Hira E. Branch, MD; Lawrence Sell, MD, and Busharat Ahmad, MD

260 Meetings

267 Category I courses

270 Deaths

272 Classified ads

273 Ad index

274 President's page; Louis R. Zako, MD

Next month in *Michigan Medicine:*

The June issue of *Michigan Medicine* will focus on the growing uses of the laser in medical treatment. Expert Michigan physicians will describe their work, with the goal of bringing their colleagues up to date on the state of the art. Also in the June issue: How to offer arbitration, recommendations for strengthening the Board of Medicine, and MSMS testimony on the omnibus medical malpractice bill.

Michigan State Medical Society

President	Louis R. Zako, MD, Dearborn Heights
President-elect	Richard J. McMurray, MD, Flint
Immediate Past President	Donald K. Crandall, MD, Muskegon
Secretary	Robert M. Leitch, MD, Battle Creek
Treasurer	Leland E. Holly, II, MD, Muskegon
Speaker	Gerald H. Mandell, MD, Detroit
Vice Speaker	Robert D. Burton, MD, Grand Rapids
AMA Delegation Rep.	Richard J. McMurray, MD, Flint

Board of Directors

Chairman	Thomas R. Berglund, MD, Portage
Vice Chairman	Carl A. Gagliardi, MD, Dearborn

District directors

District 1	Carl A. Gagliardi, MD, Dearborn
	James J. Humes, MD, Detroit
	Kenneth J. Ray, MD, Trenton
	Henry M. Domzalski, MD, Detroit
	Arthur A. Ulmer, MD, Grosse Pointe Shores
	Frank B. Walker, MD, Grosse Pointe Farms
District 2	Justin L. Sleight, MD, Lansing
District 3	William D. Walters, MD, Battle Creek
District 4	Thomas R. Berglund, MD, Portage
District 5	Harvey M. Andre, MD, Grand Rapids
	Kornelius Van Goor, MD, Grand Rapids
District 6	Richard L. Rapport, MD, Flint
District 7	Kenneth B. Herrington, MD, Bad Axe
District 8	Jack L. Barry, MD, Saginaw
District 9	Vickers C. Hansen, MD, Manistee
District 10	Charles L. Oppy, MD, Roscommon
District 11	Robert E. Paxton, MD, Fremont
District 12	Carl Hammerstrom, MD, Marquette
District 13	Kenneth E. Rowe, MD, Hancock
District 14	Marguerite Shearer, MD, Ann Arbor
District 15	Billy Ben Baumann, MD, Pontiac
	Frederick W. Bryant, MD, Royal Oak
	Joel W. Clay, MD, Mt. Clemens

Michigan State Medical Society
Warren F. Tryloff, director

Committee on Publications
Busharat Ahmad, MD, Marquette, chairman
Harvey Andre, MD, Grand Rapids
Vickers C. Hansen, MD, Manistee
Leland E. Holly II, MD, Muskegon
James H. Tisdel, MD, Port Huron

Editor
Judith Marr

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

MICHIGAN MEDICINE (ISSN 0026-2293) is the official journal of the Michigan State Medical Society, published under the direction of the Publications Committee. Published five times a month, 60 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $30.00; single copies, $1.50. Additional postage: Canada, $1 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to articles, news, exchanges, should be addressed to Judith Marr, advertising inquiries to Joyce Crum and address changes to Peg Berry, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517-337-1351.
©1984 Michigan State Medical Society

Nuclear war

I would like to make the following comments in response to Doctor Joseph Arends' letter in the March *Michigan Medicine.* There, he comments on the relative strengths of the US and the USSR nuclear stock-piles, assumes that we are the weaker side, and states that negotiations between the two countries would be in vain.

(1) We are *not* inferior to the USSR. On page 30 of the Dec. 5 number of *U.S. News and World Report* there is a diagram of the relative nuclear strengths of the two powers. We have 26,500 nuclear warheads, the USSR has 19,800. True, they are ahead of us in total megatonnage, but this is not what matters. Ten one-megaton warheads can do much more damage than one 10-megaton warhead.

In the same magazine on page 11, March 12, is a Pentagon study which states that of 31 deployed systems examined, the Pentagon rated the US superior in 17, the Soviets ahead in four, and the superpowers equal in 10.

(2) As for *not* trying negotiations, Edson W. Spencer, Chairman of Honeywell, Inc. which did a *billion* dollars worth of defense contracts last year, on page 14 of the Feb. 20 *Newsweek,* urges a two-sided ban on all short-range nuclear weapons, with a later mutual reduction on intermediate and strategic nuclear weapons to reduce the risk of accident and to wind down the arms race. The first part might take a decade, and all of it a lifetime. Here is a strong voice from the "industrial-military complex"!

Please note that what is suggested here is a mutually verifiable freeze and reduction of stock-piles. US satellites are already reporting on Soviet stock-piles, and their satellites are already reporting on ours.

(3) Even if we were not already equal to or ahead of the USSR in almost all the systems noted above, we would still be on sound ground in advocating a freeze and later reduction. The common military mistake of the Pentagon, the Administration, and of millions of the rest of us is in thinking of nuclear terms in the same way we always thought of conventional forces, i.e., a tank for a tank, a plane for a plane, a ship for a ship. The side with the fewer of the above was at a disadvantage. But in nuclear war, where each side can annihilate the other many times over, this comparison is no longer valid. If someone says, "But we can fight a limited, not a full-scale, nuclear war," we can forget it. Neither side is going to roll over and call "Uncle" while it has anything left to use.

Add Carl Sagan's "nuclear winter" concept to this, and we find that if one side launched a massive attack which was not even answered in retaliation, the attacking side itself would perish in the "winter."

A cartoon from Australia puts all the above in a few words. It has our Secretary of Defense talking to one of his colleagues and saying, "The Soviets can kill each one of us 16 times over, and we can only kill each one of them 14 times. See what a great danger they are to us!"

We and the USSR will survive or perish together, and the chances for the latter are increased with each megaton added to our two hair-trigger nuclear arsenals.

As Norman Cousins observes, "Each nation has its own national anthem, but who writes the anthem for humanity?" I claim a part of that responsibility for my profession.

John R. Rodger, MD
Kalamazoo

Arbitration statute

We read with interest Doctor Powsner's article "Medical Arbitration," in the March edition of *Michigan Medicine.* Although Doctor Powsner has accurately summarized the origin of the medical arbitration statute and the work of the Arbitration Advisory Committee, she has mischaracterized the position of the Physicians Crisis Committee (PCC).

The PCC recommended that the Arbitration Advisory Committee delay taking action until the Supreme Court ruled on the arbitration issue. The Arbitration Advisory Committee was prematurely, and now we know incorrectly, presuming that the Supreme Court would find the law deficient in some respects. In fact, the Supreme Court in a five to one decision has upheld the arbitration statute in all respects and has not required that any changes be made. The Supreme Court said that the arbitration agreement in its present form provides proper disclosure and is a valid and binding legal document.

Doctor Powsner would have us reopen to new challenges a system that the Supreme Court has upheld and which, as the evaluation demonstrates, when used works effectively. The PCC believes that the best course for medicine to follow is to apply its efforts to fully implement — not change — the arbitration statute. Now hospitals and doctors alike should work to make arbitration a viable alternative to the costly, time consuming, and frustrating court system that we encounter in Michigan.

In any case, Doctor Powsner has ignored the substantive basis for PCC's objection to the proposed changes in the arbitration statute, to-wit, that those changes will make arbitration far more difficult, rather than easier, to utilize as an effective alternative dispute mechanism. We would assume that the most desirable status of the law for the Bar Association, and particularly its trial lawyer wing, would be to have an arbitration statute on the shelf to trot out for public display in every controversy, yet to have that statute so encumbered with conditions and regulations that it is not often used. That in fact is the direction, at least, that the Advisory Board is going with its current recommendation.

Arthur B. Eisenbrey, MD
W. Peter McCabe, MD
H. Harvey Gass, MD
Detroit

CME in Michigan is growing up

By Robert L. Tupper, MD

Doctor Tupper served as a volunteer CME surveyor for the AMA from 1968-74, and subsequently, on the AMA's CME Review Committee in 1975 and 1976. He also has served as an AHME appointee to the LCCME Review Committee from 1977-79, on CACME from 1979-81 and currently as an AMA appointee to the ACCME Review Committee since 1981. He also has served since 1975 on the MSMS Committee on CME Accreditation. He is director of medical education at Blodgett Memorial Medical Center, Grand Rapids.

There is great promise today for truly practice-linked continuing medical education, as well as individualized interactive CME.

Continuing medical education has come to occupy its rightful place. It now is a means of reviewing and refreshing fundamental concepts, in the course of reassuring physicians that the care they furnish is current and appropriate. It also is the means of rapidly transmitting new laboratory discoveries and concepts to the front line trenches of health care delivery.

It has been an interesting journey from the early days of modern continuing medical education. The development of today's CME offerings is clearly outlined through the highlights of the MSMS involvement in the field.

As we complete the first decade of the MSMS role as an accreditor of Michigan continuing medical education programs, I would like to review where our profession has been in CME, and where we may be headed.

The literature shows initial evidence of attempts at CME beginning around 1910. However, there were no organized approaches until after World War II, when the University of Michigan Office of Postgraduate Medicine, for instance, came into being. Many Michigan physicians remember the 1950's and early 1960's, when community hospitals were visited by circuit riding professors, who ranged from brilliant and exciting to "Old Shifting Dullness." Then, topics and content frequently had no relationship to the needs of the audience or to the patient care problems at that particular institution.

Some history

It was during that same period that the American Academy of General Practice first required its members to participate in continuing medical education. In 1955, the American Medical Association began its initial studies of continuing medical education. The AMA Council on Medical Education formally implemented the first national CME accreditation system in 1967, approving several medical schools and some large specialty societies. By 1969, we saw the advent of the AMA Physicians Recognition Award, and at the same time, the move within some state medical societies to require participation in accredited CME programs to maintain membership.

Driven by a sense that the profession could demonstrate response to public accountability needs, and by the perception that this effort would somehow alleviate the burgeoning malpractice problem, many more hospitals and specialty societies began requesting accreditation as CME providers.

It quickly became clear that the AMA system simply could not handle the increasing volume of accreditation requests, and that the system needed significant change.

The AMA then began to delegate authority to state medical societies to survey hospitals and institutions, and to accredit them to offer formal continuing medical education programs.

In 1974, MSMS was one of the first states to apply for this authorization, and shortly thereafter, it was officially recognized. Fifty-five states and territories subsequently acquired this same authority, and 20 states eventually required fixed numbers of hours of continuing medical education for relicensure of physicians.

That delegated mechanism was transferred in 1977 to the newly formed Liaison Committee on Continuing Medical Education (LCCME), as a national body empowered to accredit all CME. However, in 1979, the AMA withdrew from this cooperative effort, and formed its own Committee on the Accreditation of Continuing Medical Education (CACME). For the next two years, CACME and the old LCCME (minus the AMA) continued as a dual accreditation system.

In 1981, the principles causing that separation were resolved, and a new body known as the Accreditation Council on Continuing Medical Education (ACCME) came into being. Today it is the official national accrediting body. It delegates authority to Michigan through the MSMS Committee on Continuing Medical Education Accreditation, as the accreditor of intrastate continuing medical education.

So much for the history of accreditation mechanics. What about the history of the CME process? When we look at 1970 literature, we see an emerging feeling that CME should deal with what we need to know as revealed by medical audit findings, and not so much with what we wanted to know. This came from the early concept that CME should result in improved performance in the delivery of patient care.

As we move into the mid-1970s, we see beginning evidence of concern about evaluation of CME and about determining whether CME really made a difference in patient care. At this point, we began to realize that gaps in performance were not really based so much on lack of knowledge per se, and frequently were better dealt with by peer discipline than by CME. It is worth noting here that there probably have been less than 10 articles in US literature which show that mandatory CME has directly influenced the quality of patient care delivered by physicians.

As we move into the late 1970s, we begin to encounter a relative explosion in the volume of CME offerings. This is perhaps best reflected by Jim Thorpe's comment, "It must have been on the eighth day that God created CME meetings, and when that day was pruned from the calendar, meetings merely flowed into all other available spaces on the other seven days."

During this period we witnessed the creation of large numbers of proprietary, or for-profit CME organizations, built upon boat cruises, ski trips and one man shows. It has been estimated that these efforts helped raise the cost of continuing medical education until it exceeded $3,000,000,000 per year, all of which was included as part of our national health care cost.

Quality emphasized

The increase in CME activities now has leveled off, and we are entering a period of increased emphasis on the quality of CME. Nevertheless, we still remain basically in a mindset that continuing medical education should give rise to better clinical performance.

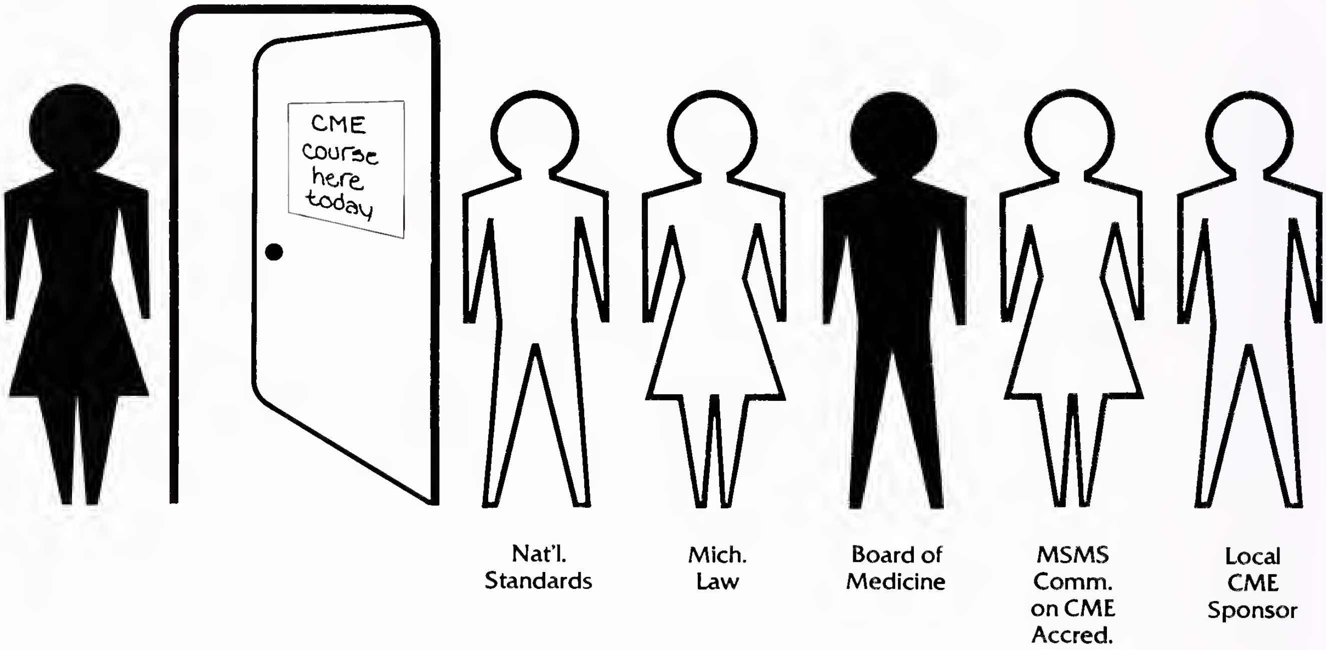
At the same time, we now are beginning to realize that much of continuing medical education refers to knowledge bases and continues to emphasize the old school approach of "memory and recall," as perhaps best evidenced by use of pre-and post-test methods to evaluate the worth of CME.

Sadly, we still have not reached

Continued on page 231

By Vada L. Davis

How the accreditation process works



The average Michigan physician may not realize that the CME courses offered in the state are backed by a complicated, highly-organized system of standard-setters and regulators.

The MSMS Committee on CME Acreditation now approves 84 institutions and organizations within Michigan to offer CME programs for Category I credit. (See list page 231.)

This MSMS activity is part of a complicated state, local and national process to ensure that physicians earn the required hours of continuing medical education and that the courses the physicians take make a contribution to improving patient care — the only valid reason for the CME requirements in the first place.

Five criteria

The Committee, chaired by Donald J. Aiken, MD, Okemos general practitioner, accredits each institution based on whether its total CME program meets the standards and criteria established by the Committee and outlined in its Accreditation Manual. The criteria require that Category I programs:

1) Be based on educational need assessment to improve patient health care.

2) Have educational objectives for those attending derived from the identified needs; whether knowledge, skills, attitudes or performance are to be changed.

3) Be a planned learning experience based on the objectives and with specific program organization, developmental planning, and responsibility placement. The educational method used should be determined by the needs and objectives.

4) Have an evaluation method for each program (or groups of programs) and of the entire CME

Ms. Davis is manager, MSMS Department of Administration and Physician Education.

program of the institution in terms of impact on the quality of patient care).

5) Have retrievable attendance records for each program.

The standards deal with such details of the program as administration, budget, teaching staff, curriculum, facilities, educational methods and methods of evaluation.

Taken together, the criteria and the standards assure that an organization's CME programs meet the commitment to improving health care through continuing medical education. Such Category I programs must be designed principally for physicians, promoted to physicians and have significant physician attendance.

Fees for accreditation are $250 per survey application for hospitals and $150 for other organizations, plus expenses and per diem for surveyors.

MSMS role

Direct MSMS involvement in CME accreditation began when the Michigan Legislature amended the Medical Practice Act in 1975 to require that physicians complete a specified number of hours of CME in courses or programs approved by the Michigan Board of Medicine, in order to renew their medical licenses. This law has been amended to require 150 hours of CME related to the practice of medicine and medical ethics over a three-year period. At least 75 hours of the 150 must be in Category I. One third of the medical licenses in Michigan expire each year.

The Michigan Board of Medicine has accepted the standards developed and utilized by the MSMS Committee on CME Accreditation in accrediting instate institutions and organizations for certifying programs to conduct Category I CME. The Board accepts attendance at programs so certified as meeting the requirements for relicensure in Michigan. The MSMS Committee is concerned only with Category I, not with any of the other categories of CME education.

Also, since 1975, the MSMS Committee on CME Accreditation has participated in a national Continuing Medical Education Program, now supervised by the Accreditation Council for Continuing Medical Education (ACCME). Seven organizations sponsor ACCME: The American Medical Association, the American Hospital Association, the Association of American Medical Colleges, the Council of Medical Specialty Societies, the American Board of Medical Specialties, the Association for Hospital Medical Education and the Federation of State Licensing Boards. At present, national accreditation authority is exercised by an ACCME subcommittee called the Committee for Review and Recognition of State Medical Societies as Accreditors of Continuing Medical Education Providers (CRR). ACCME authorizes the MSMS Committee on CME Accreditation to accredit institutions within Michigan to offer intrastate programs for CME credit acceptable at the national level for the Physicians' Recognition Award (PRA).

(The MSMS criteria and standards are based on the Essentials promulgated by ACCME. New Essentials have recently been approved by ACCME and the MSMS Accreditation Manual is in the process of revision to incorporate the changes, which are very similar to the current Essentials but with a change in focus. The revised Manual is scheduled for publication in late summer or fall, 1984.)

Basic structure

Briefly:

The Michigan Legislature establishes the law re CME requirements for relicensure.

The Michigan Board of Medicine enforces it.

The Accreditation Council for Continuing Medical Education (ACCME) establishes national standards.

The MSMS Committee on CME Accreditation establishes criteria and standards for programs utilizing the Essentials established by ACCME for accreditation. It conducts surveys and accredits institutions and organizations meeting those Essentials. It is the accrediting organization for Michigan intrastate CME providers.

An accredited institution or organization providing CME in Michigan (such as the MSMS Committee on CME Programming) has the responsibility of certifying which of its own CME programs should be certified as meeting the criteria and standards and therefore being accredited. With certain restrictions, it can co-sponsor programs provided by other groups, as well.

Some organizations within the state must obtain accreditation nationally from ACCME. Generally, these include state medical societies, schools of medicine and other institutions which sponsor continuing medical education activities on a regular and recurring basis in which more than one third of the registrants are from beyond bordering states, or from four or more states on a regular basis.

By Sherry L. Fent

How to cosponsor a course with MSMS CME Committee

The MSMS Committee on CME Programming has been accredited by the MSMS Committee on CME Accreditation to present Category I credit activities since 1976. The mission of the CME Programming Committee is to encourage, organize and present high quality educational programs for physicians practicing in Michigan. The committee is chaired by Samuel M. McMahon, MD, Lansing, vice president for medical affairs, Ingham Medical Center.

Our best recognized contribution is the Annual Scientific Meeting, which is usually attended by between 1,200 and 1,500 physicians, and awards thousands of Category I credit hours each year.

The committee also sponsors annual programs in sports-medicine and maternal/perinatal health. These conferences, which attract hundreds of physicians, nurses, medical students, medical assistants, and athletic trainers and coaches, strive to promote the concept of health care professionals as a "team."

We are committed to assuring that our conferences are devoted to the goal of improving patient care in any of the fields where medicine is practiced.

Cosponsorship

Another important activity of the Committee on CME Programming is its co-sponsorship of selected CME programs with other, non-accredited medical groups. Many of these groups have representatives on the committee to provide liaison and to assure committee input into the program planning. The policies and procedures of co-sponsorship are based on the principles of the AMA Physician's Recognition Award and of the MSMS Committee on CME Accreditation.

Co-sponsorship of programs is not a "rubber stamp" relationship, as the CME Programming Committee will only co-sponsor a program for which it is willing to accept full responsibility for the educational quality.

The Committee has established a procedure to ensure input on each cosponsored activity. This procedure assigns a committee representative to attend any program planning sessions and to report on progress. If time does not allow this, then the applicant is invited to attend a committee meeting, to present the co-sponsorship application, and answer any questions from committee members.

There are many factors which influence the committee's decision as to whether or not to co-sponsor another group's program, but the following are of primary importance:

1. The program content must be based on educational needs of the proposed audience.
2. There must be clearly stated objectives, followed by specific goals.
3. The programming approach and educational methods must be described, as well as the rationale for selection of faculty.
4. There must be an acceptable evaluation mechanism and attendance-keeping process.
5. The emphasis of any proposed program must be upon improved patient care, regardless of the topic.

How to apply

The Committee on CME Programming meets quarterly, or upon the work demand, and will accept co-sponsorship applications at any time. The procedure to apply for cosponsorship of programs is as follows:

1. Call or write and request an application form. Applications must be received by the CME Programming Committee at least 90 days prior to the proposed program, or at a time prior to initial planning so that the Committee may be "sufficiently involved" during initial stages of the planning.
2. Upon receiving the application, a committee representative will be assigned to counsel and assist the applicant and to participate in the program development.
3. If the application is not approved, the Committee will provide a written explanation and, if appropriate, a method of reapplication may be suggested.
4. If the application is approved, the applicant must comply with certain standards regarding the certification statement, the evaluation of the program and the attendance records.
5. MSMS will assist in promoting the event through its publications and can provide some staff support in developing appropriate forms and CME certificates.

During the past year, the Committee co-sponsored eight Category I CME conferences with six different organizations.

In addition to its co-sponsorship activities, the CME Programming Committee has helped arrange several regional CME programs and two Category I self-study articles and quizzes through *Michigan Medicine*. Through all of these activities, the committee strives to provide high quality, reasonable and accessible CME programs to as many physicians in Michigan as possible.

Ms. Fent is chief, MSMS Section on Physician Education.

Acquired Immune Deficiency Syndrome (AIDS)

By Evelyn J. Fisher, MD

With this issue of *Michigan Medicine,* the MSMS CME Programming Committee continues its new feature. This special section contains an educational article of general interest to physicians, followed by a quiz which can be filled out and returned to MSMS headquarters. The deadline is Sept. 1. Physicians who correctly answer at least 80 percent of the questions will earn one hour of Category I CME credit, for the minimum charge of $3 for MSMS costs. The quiz will be evaluated and returned to you with appropriate comments. In addition, there is space allowed for you to comment and to ask further questions.

Auto immune deficiency syndrome (AIDS) is a most extraordinary illness. It offers us an exciting and invaluable opportunity to learn about how we defend ourselves against infection and cancer.

Thus, AIDS is of great potential benefit to all, except those who suffer from it or fear they may. For them, this awesome disease has been an unending tragedy compounded by the ugly spectre of social and religious hysteria recalling the Dark Ages.

Because most Michigan physicians have not seen a case of AIDS, and may never, this article is not about the management of AIDS. Rather, it has four major goals: (1) to explain what AIDS is; (2) to correct common misconceptions about AIDS; (3) to provide information on how and when to suspect AIDS; and (4) to answer common questions about prevention of AIDS.

Broadly defined, AIDS is a newly recognized complex transmissible disease causing human deficiency, mainly of the cell-mediated type. The immune deficiency is manifest clinically as (1) infection — mainly opportunistic viral, parasitic, fungal and mycobacterial; (2) cancers — mainly Kaposi's sarcoma and lymphoma; and (3) other immunologic phenomena.

The immune abnormalities identified to date in AIDS are not specific. **There is no specific test for AIDS.** The diagnosis of AIDS is a clinical one, supported by compatible laboratory data. The Centers for Disease Control (CDC) defines AIDS by the presence of specific opportunistic infections and/or cancers in persons with compatible immune abnormalities and without other causes of immune deficiency. The CDC defintion of AIDS probably represents the most severe form of a disease which has milder and non-fatal forms. For prognostic, statistical and Social Security purposes, it is best to use the CDC definition. At the same time, physicians should be aware of the much broader spectrum of suspected AIDS-related disorders (q.v.)

Epidemiology and transmission

AIDS was first recognized in 1981, but cases date back to 1978. AIDS occurs mainly in the United States (4,000 cases), with the highest incidence in New York, San Francisco, Los Angeles, and Miami. Most foreign cases are in Canada, Haiti, Western Europe and Central Africa. Unofficially, 24 cases have occurred in Michigan since 1981, nine of them in the last four months.

Although anyone can get AIDS, 95 percent of US cases have occurred in one of the following six increased-risk groups. AIDS should come to mind in the differential diagnosis of fever, weight loss, lymphadenopathy and cancer in persons in these groups. As physicians are often unaware of a patient's sexual preference, it is well to keep in mind that about 10 percent of adults are homosexual or bisexual.

1. Homosexual or bisexual men (*1 in 3,000) — risk is mainly in those who at sometime in the preceding five years have had many sexual partners.
2. Intravenous drug abusers
3. Hemophiliacs (*1 in 1,000) and rarely other blood product recipients ($\leq$1 in 100,000).
4. Haitians (*1 in 5,000) — most Haitian AIDS patients actually have other risk factors, *e.g.,* male bisexuality.
5. Sexual partners of persons at increased risk.
6. Infants born to parents at increased risk.

Doctor Fisher is with the Division of Infectious Diseases and Hospital Epidemiology, Henry Ford Hospital, Detroit.

*The approximate incidence of AIDS in a given population

Seven percent of U.S. cases are found in women.

AIDS is of a very low degree of contagiousness. It is *not* transmitted through the air or by casual social contact. It is transmitted through sexual relations and blood. Transmission can occur with either heterosexual or homosexual intercourse. Current evidence suggests the following transmission potential for body fluids other than blood: high for semen; low or nil for saliva; none for sweat; and uncertain for urine, feces and breast milk.

Blood transmission has occurred via parenteral administration of blood or blood products (but not via accidental needlestick to date), via intravenous drug abuse and from mother to infant before or at delivery. Severe hemophiliacs using commercial factor VIII concentrate are exposed to the blood products of up to 200,000 persons per year. **It is important to emphasize that there have been no documented cases of AIDS transmission to medical personnel, family or household members caring for AIDS patients (except sexual partners) to date.** The adult incubation period appears to range from four months to four years (in transfusion-associated cases, a minimum of 10 months and an average of two years). Infants have all become ill between birth and nine months of age.

Unfortunately, from the standpoint of prevention, it appears that the majority of transmissions are from relatively asymptomatic carriers, who may have mild non-diagnostic immune abnormalities. It is useful to compare AIDS and hepatitis B. AIDS is like hepatitis B in transmission and in populations at greatest risk. But, importantly, AIDS is unlike hepatitis B in being much less contagious, having a much longer incubation period, and in not being a risk to medical personnel to date.

CDC definition of AIDS: specific infections and cancers

The two cancers are Kaposi's sarcoma under age 60, and primary central nervous system lymphoma. The opportunistic infections are all rare: Pneumocystis carinii pneumonia; Candida esophagitis; chronic mucocutaneous herpes simplex (perioral or anogenital ulcer lasting over five weeks); cryptococcal meningitis; disseminated atypical mycobacterial infection; toxoplasma encephalitis; visceral or disseminated cytomegalovirus (CMV) or herpes simplex infection; chronic cryptosporidial enterocolitis (lasting over four weeks); disseminated candidiasis or strongyloidiasis; and progressive multifocal leukoencephalopathy.

Suspected AIDS-related disorders

The following disorders are more frequent in persons with AIDS, in persons who later develop AIDS, and in persons who are at increased risk of AIDS. However, the likelihood of any relationship to AIDS cannot be predicted in a given case, only the possibility. **In persons at increased risk of AIDS,** these disorders should be regarded as **potentially** indicating an AIDS carrier state in terms of treatment and prevention, but **not** prognosis.

1. **Suspected mild AIDS** (includes lymphadenopathy syndrome, "Pre-AIDS," "AIDS Prodrome," "AIDS-Related Complex," "Wasting Syndrome," etc.)

One or more of the following (generally associated with some immune abnormality):

(a) **Chronic lymphadenopathy** — defined as nodes ≥ 1 cm in ≥ 2 areas outside the inguinal for ≥ 3 months. Node biopsy most often shows hyperplasia.

(b) **Non-specific symptoms** — usually fatigue, weight loss, fever and/or chronic diarrhea.

(c) **Infections and immunologic phenomena** (see 2 and 3 below). Such suspected mild cases outnumber overt AIDS by at least 10 times, and are of uncertain prognosis. To date, of those with lymphadenopathy and/or non-specific symptoms, on the whole only 10 percent or less (range 1-25%) have progressed to overt AIDS within a year; up to 50 percent have improved; some have recovered completely. For this reason, the terms "pre" or "prodromal" or "early stage AIDS" are best used in retrospect only.

2. **Infections.** The most common are chronic thrush in adults, recurrent zoster and pulmonary or miliary tuberculosis. Ordinary bacterial infections are seldom a major problem in adults with AIDS.

3. **Immune phenomena.**

(a) Immunoproliferative — hypergammaglobulinemia; lymph node biopsy findings of follicular hyperplasia or involution, angioimmunoblastic lymphadenopathy or angiofollicular lymphoid hyperplasia (Castleman's disease).

(b) Autoimmune — most common is thrombocytopenic purpura.

4. **Cancers**

(a) Lymphomas — usually primitive B-cell, *eg.* Burkitt's, diffuse undifferentiated non-Hodgkin's immunoblastic sarcoma.

(b) Squamous carcinomas — of oropharynx and anogenital area.

Symptoms and signs

In general, AIDS symptoms and signs are not specific. The most common presenting syndromes of AIDS and suspected AIDS-related disorders are:

1. The "wasting syndrome" (or "AIDS-related complex") — with weight loss (>10 percent), fever, fatigue, diarrhea, lymphadenopathy and often thrush; lasts weeks to months and may or may not evolve to CDC AIDS.
2. Chronic lymphadenopathy
3. Relatively asymptomatic cutaneous Kaposi's sarcoma
4. Opportunistic infection — usually pulmonary, gastrointestinal or neurologic.

Localized symptoms and signs most commonly are cutaneous: purplish patch or nodule on skin or in mouth (Kaposi's), oral or anogenital

Continued on page 265

the point where continuing medical education is truly practice-related. Equally sadly, our entire system of continuing medical education regards the reading of textbooks and journals as a very minor entity, while this author still considers them to be the backbone of CME for practicing physicians.

We have witnessed the advent of television tapes and programs to help us acquire continuing medical education, but we continue to be moderately disappointed by the value of that approach. Most recently, however, many of our larger national specialty societies have become outstanding in the development of packaged CME programs, which are in fact, practice-related. The American College of Obstetrics and Gynecology and the American College of Radiology are two examples that stand out as major pioneers in this area.

These are the developments of the future. They are coming over the horizon with the advent of satellite TV and home video disk recorders, coupled with the emerging ability to relate those to the office computer.

It must be pointed out, however, that this new practice link approach will merely supplement existing continuing medical education. I am convinced that the cornerstone of CME will remain the textbooks and journals of medicine, be they in printed or electronic form.

You may well not subscribe to the concept of mandatory CME for relicensure of physicians in Michigan, and frankly, I too, have mixed feelings about it. We cannot, however, escape the conclusion that the quality of CME offered and available in Michigan over the past decade has increased enormously.

I predict that over the coming decade, with the increasing availability of technology and professional capability, the value and essential nature of CME will become progressively more important to each individual physician in a practice-linked electronic mode.

Organizations accredited to provide Category I CME

The following have been accredited directly by the AMA or by MSMS CME Accrediting Committee. Physicians may wish to write to the hospitals and organizations that are accredited and ask to be placed on mailing lists for announcements about future programs.

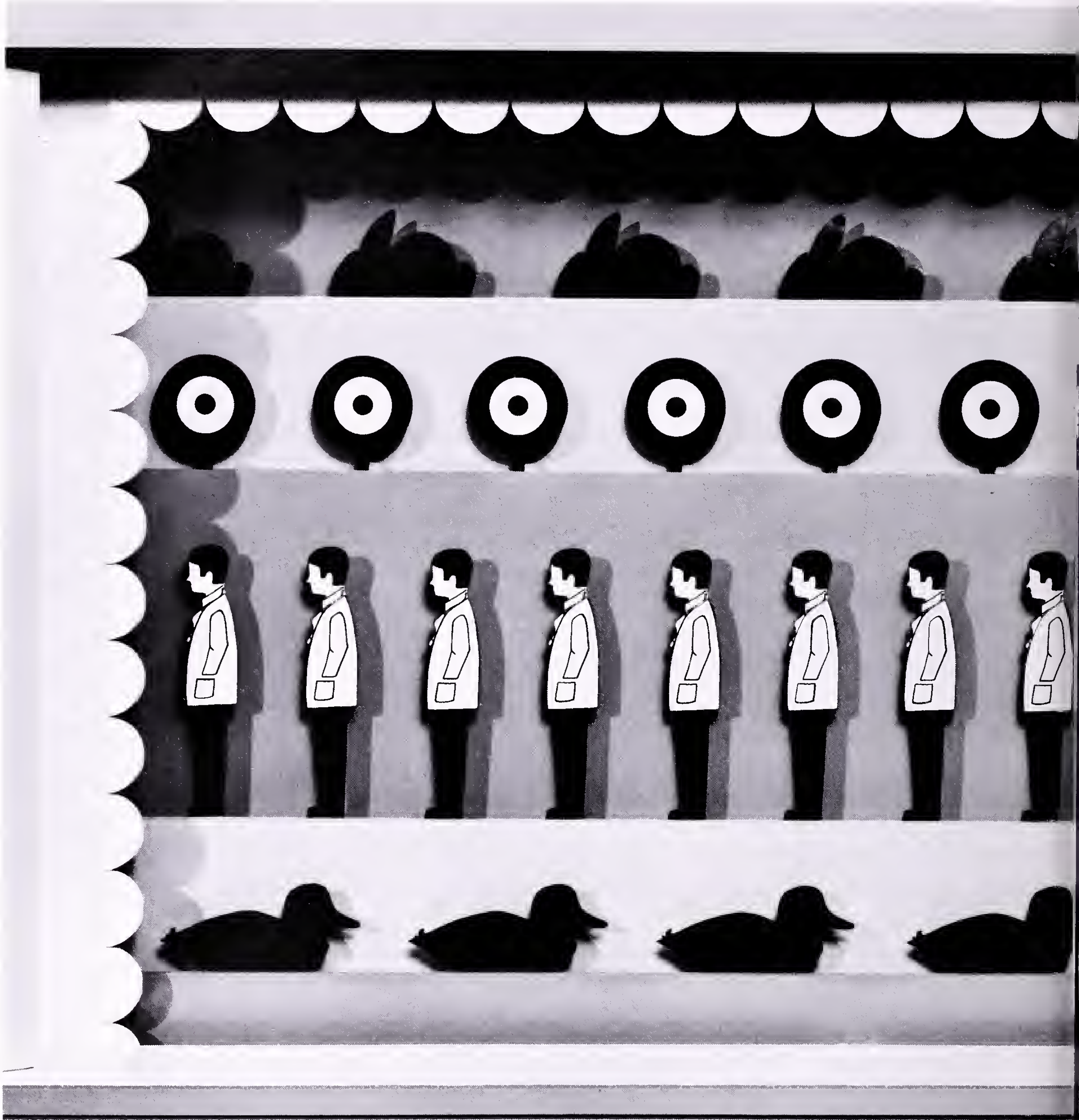
Organizations:

Academy of Plastic Surgeons, Grosse Pointe Woods
American Academy of Clinical Toxicology, Detroit
American Academy of Pediatrics-Michigan, Grand Rapids
American Cancer Society, Lansing
American Lung Association-Michigan/Southeast Michigan, Lansing
American Physiological Society, Ann Arbor
American Society of Colon and Rectal Surgeons, Detroit
American Society of Dermatopathology, Ann Arbor
Ann Arbor Psychiatric Association, Ann Arbor
Bay Medical Education, Bay City
Center for Forensic Psychiatry, Ann Arbor
Lakeshore Continuing Medical Education, Inc., Muskegon
Michigan Academy of Family Physicians, Lansing
Michigan Academy of Plastic Surgeons, Rochester
Michigan Department of Mental Health, Office of Resource Development, Lansing
Michigan Dermatological Society, Southfield
Michigan Heart Association, Southfield
Michigan Ophthalmological Society, Harper Woods
Michigan Psychoanalytic Institute, Southfield
Michigan Psychoanalytic Society, Southfield
Michigan Society of Anesthesiologists, East Lansing
Michigan State Medical Society
Michigan State University, East Lansing
National Institute for Burn Medicine, Ann Arbor
Orthopaedic Guild, St. Joseph
Public Health Consortium, Ann Arbor
Southfield Rehabilitation Center
Southwest Michigan Area Health Education, Kalamazoo
Upjohn Company, Kalamazoo
Wayne State University, Detroit
West Shore Consortium for CME, Manistee

Hospitals:

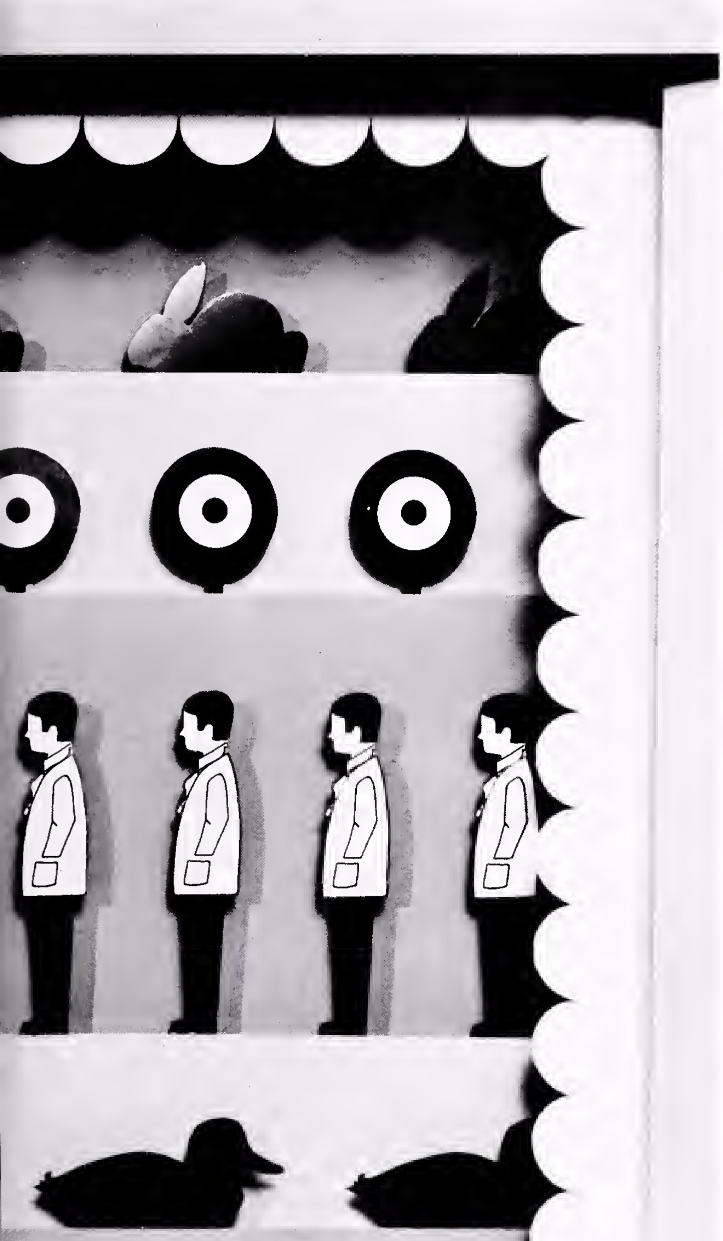
Annapolis Hospital, Wayne
Beaumont Hospital, Royal Oak
Bell Memorial Hospital, Ishpeming
Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Medical Center, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic/Northern Michigan Hospital, Petoskey
Butterworth Hospital, Grand Rapids
Central Michigan Community Hospital, Mt. Pleasant
Chippewa County War Memorial Hospital, Sault Ste. Marie
Community Health Center - Branch County, Coldwater
Community Hospital, Battle Creek
Cottage Hospital, Grosse Pointe Farms
Crittenton Hospital, Rochester
Detroit-Macomb Hospital Corporation
Dickinson County Memorial Hospital, Iron Mountain
Edward W. Sparrow, Lansing
Ferguson-Droste-Ferguson Hospital, Grand Rapids
Foote Memorial Hospital, Jackson
Grace Hospital, Detroit
Gratiot Community Hospital, Alma
Hawthorn Center, Northville
Henry Ford Hospital, Detroit
Heritage Hospital, Taylor
Herrick Memorial Hospital, Tecumseh
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Huron Memorial Hospital, Bad Axe
Ingham Medical Center, Lansing
Kalamazoo Regional Psychiatric Hospital, Kalamazoo
Leila Hospital & Health Center, Battle Creek
Marquette General Hospital, Marquette
McAuley Health Center, Ann Arbor
McLaren General Hospital, Flint
Mecosta County General Hospital, Big Rapids
Mercy Hospital, Port Huron
Midland Hospital Center, Midland
Mt. Carmel Mercy Hospital & Medical Center, Detroit
Munson Medical Center, Medical Staff, Traverse City
North Detroit General Hospital, Detroit
Northville Regional Psychiatric Hospital, Northville
Oakwood Hospital, Dearborn
Outer Drive Hospital, Lincoln Park
Pennock Hospital, Hastings
Pontiac General Hospital, Pontiac
Port Huron Hospital, Port Huron
Portage View Hospital, Hancock
Providence Hospital, Southfield
Saginaw Cooperative Hospital, Inc., Saginaw
Saline Community Hospital
Saratoga General Hospital, Detroit
Sinai Hospital - Detroit, Detroit
Southwest Detroit Hospital, Detroit
St. Francis Hospital, Escanaba
St. John Hospital, Detroit
St. Joseph Hospital (East & West), Mt. Clemens
St. Joseph Hospital, Flint
St. Joseph Mercy Hospital, Pontiac
St. Lawrence Hospital, CME Department, Lansing
St. Mary Hospital, Medical Staff, Livonia
St. Mary's Hospital, Grand Rapids
Traverse City Regional Hospital, Traverse City
University of Michigan Medical Center, Ann Arbor
VA Hospital, Battle Creek
VA Medical Center, Iron Mountain
William Beaumont Hospital Corporation, Royal Oak
Ypsilanti Regional Psychiatric Hospital, Ypsilanti

If you become the target of a



©1983 MPMLC

professional liability claim...



You will be glad you have Michigan Physicians.

Michigan Physicians has been solving complex medical professional liability problems since 1976. With the state's largest and most experienced claims staff, Michigan Physicians works with you to resolve claims (and incidents) that most physicians have never faced in their careers.

In a changing legal environment, you need the best coverage you can buy because the risk of a professional liability claim is becoming greater every day.

For a confidential rate quotation and more information about Michigan's leading physician-owned insurance company, call or write the office in your area.

Michigan Physicians
Mutual Liability Company

1305 Abbott Road
East Lansing, MI 48823
(517) 351-1150
(800) 292-1926

6735 Telegraph Road
Suite 205
Birmingham, MI 48010
(313) 647-5550

Endorsed by the Michigan State Medical Society

By Stephen Bachleda

Medicaid's PPSP — Is it working?

Preliminary surveys show that the Medicaid Physician Primary Sponsor Plan, which MSMS was so instrumental in establishing, is helping the state hold down the cost of administrating the giant health care public assistance program.

In July of 1982, the Michigan Department of Social Services began implementing a proposal presented by MSMS and MAOPS — the Medicaid Physician Primary Sponsor Plan (PPSP). The thrust of the policy was to enroll Medicaid recipients with a single physician "sponsor" or HMO which would provide or authorize all primary care received by the recipient. One major goal was to achieve declines in unnecessary use of medical services, and thereby to save public dollars.

Study of use

The department of social services established a short term and a long term study to evaluate use trends. The short term study involved a random sample of 63 recipients enrolled in the PPSP in January 1983 and a control group of 60 recipients who were being kept out of the PPSP. We analyzed three quarters of pre-PPSP data and two quarters of post-PPSP data to determine if

Continued on page 236

Table 1

Physician Primary Sponsor Plan utilization trends.

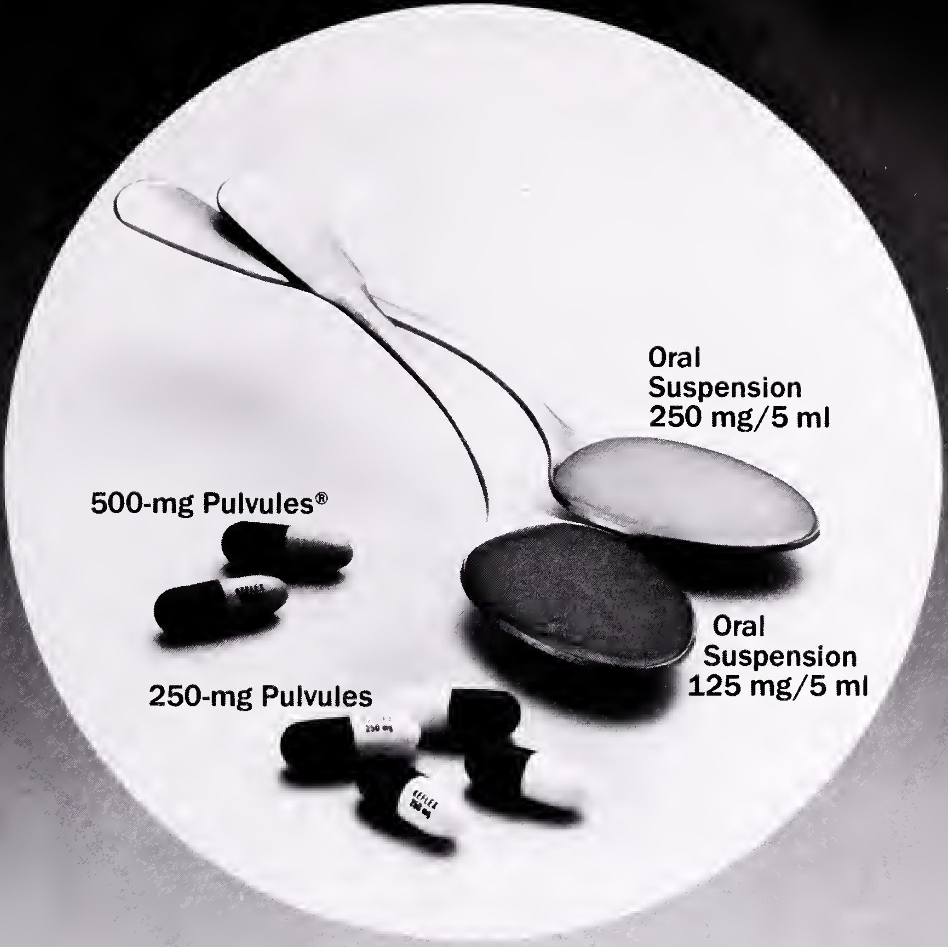
	Pre-PPSP Quarterly Average	Post-PPSP Quarterly Average	Percentage Change
Total Payments			
PPSP group	$256.24	$144.72	−43.5%
Control group	279.06	188.76	−32.4%
Number of Different Providers			
PPSP group	3.28	2.30	−29.9%
Control group	2.41	2.55	+ 5.8%
Physician Payments			
PPSP group	$ 73.23	$ 47.27	−35.4%
Control group	55.20	55.17	− .1%
Number of Different Physicians			
PPSP group	1.507	.966	−35.9%
Control group	.977	1.045	+ 7.0%
Physician Ambulatory Payments			
PPSP group	$ 24.56	$ 14.17	−42.3%
Control group	13.94	14.77	+ 6.0%
Outpatient Hospital Encounters			
PPSP group	.708	.143	−79.8%
Control group	.237	.161	−32.1%
Inpatient Hospital Payments			
PPSP group	$ 89.94	$ 37.95	−57.8%
Control group	157.79	42.91	−72.8%
Pharmacy Payments			
PPSP group	$ 31.37	$ 29.97	− 4.5%
Control group	26.65	29.00	+ 8.8%
Number of Different Pharmacies			
PPSP group	.846	.768	− 9.2%
Control group	.712	.830	+16.6%
Total Prescriptions			
PPSP group	4.02	3.71	− 7.7%
Control group	3.02	3.31	+ 9.6%
Number of Scheduled/Abusive Rx			
PPSP group	.787	.616	−21.7%
Control group	.616	.873	+41.7%
Number of Laboratory Procedures			
PPSP group	3.734	1.857	−50.3%
Control group	1.876	1.864	− .6%
Number of Radiology Procedures			
PPSP group	.495	.339	−31.5%
Control group	.299	.483	+61.5%
Total Payments Minus Inpatient Hospital Payments			
PPSP group	$166.30	$105.78	−36.4%
Control group	121.28	115.31	− 4.9%

Source: Medical Services Administration, Michigan Department of Social Services

---

Stephen Bachleda, of Lansing, is a departmental analyst for the Medical Services Administration, Department of Social Services, and is assigned to the Physician Primary Sponsor Plan. Mr. Bachleda has a bachelor of arts degree in political science from the University of Michigan and a master's degree in labor and industrial relations from Michigan State University.

Easy To Take


Oral
Suspension
250 mg/5 ml
500-mg Pulvules®
Oral
Suspension
125 mg/5 ml
250-mg Pulvules

Keflex®
cephalexin

Additional information available to the profession on request.

DISTA
420113

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

Chart 1: Mean Amount of Physician Ambulatory Payments

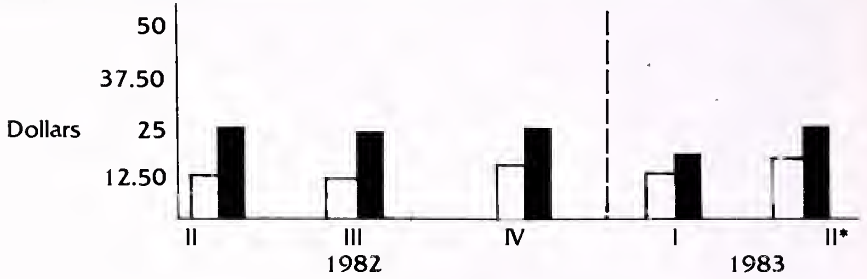
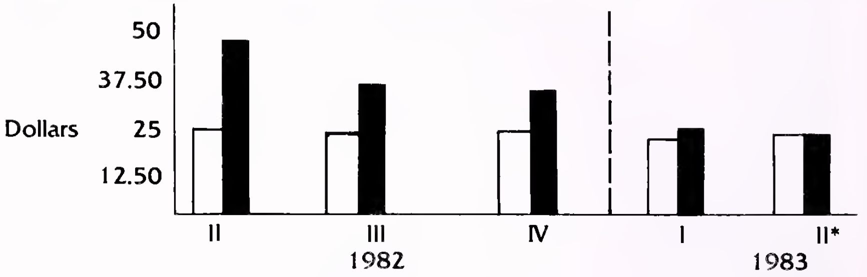


Chart 2: 75th Percentile of Physician Ambulatory Payments



* Data based on incomplete billings (approximately 95% complete)

■ Represents services received by PPSP group.

☐ Represents services received by control group.

Charts 1 and 2

Total physician ambulatory service payments for a random sample of PPSP enrolees and a control group for calendar year quarters April 1982 through June 1983. First quarter of PPSP enrollment is Quarter I, 1983.

Means and 75th percentiles are displayed. Original sample sizes were 63 for the PPSP group and 60 for the control group.

Source: Medical Services Administration, Michigan Department of Social Services

PPSP enrollment resulted in greater declines in use of health services than were being seen in the non–PPSP population.

The results in several areas have been very good and are reflected in Table 1. The number of total providers, physicians, and pharmacies patronized all declined significantly.

For example, the number of different physicians seen by the PPSP group declined by 35.9 percent, compared to an increase of 7 percent for the control group. Payments to physicians also declined for the PPSP group by 35.4 percent, compared to a .1 percent decline for the control group. The decline in physician ambulatory service payments was 42.3 percent for the PPSP group compared to an increase of 6 percent for the control group. Total prescriptions declined by 7.7 percent for the PPSP group, compared to an increase of 9.6 percent for the control group. The decline in the use of scheduled, potentially abusive prescriptions was dramatic, with the PPSP group's usage declining by 21.7 percent, compared to a control group increase of 41.7 percent. The number of laboratory procedures provided to the PPSP group declined by 50.3 percent, compared to a control group decline of only .6 percent. Outpatient hospital encounters dropped by 79.8 percent for the PPSP group, compared to a 32.1 percent decline for the control group.

We could not draw conclusions from the study about the impact on inpatient hospital expenditures. Hospitalization incidents for each group per quarter ranged from 0 to 6, numbers so small that no statistical significance can be attached to the results. (Sample sizes between 1,000 and 2,000 would be necessary to generate an acceptable data base.) Inpatient hospital expenditures also heavily weighted the total Medicaid payments statistics, making conclusions about that area impossible. (A 43.6 percent decline in total Medicaid payments was observed for the PPSP group compared to 32.4 percent for the control group.) When total payments were examined *after* subtracting inpatient hospital payments, a decline of 36.4 percent was observed for the PPSP group compared to a 4.9 percent decline for the control group.

Charts 1 and 2 show the effect of the PPSP on one medical service dimension, physician ambulatory service payments. The major impact of the PPSP was to reduce use rates for recipients receiving more services than the norm (the 75th percentile is a rough indicator for this group). The PPSP appears to have little or no effect on measurements of the 25th and 50th percentiles in most categories. (Note: The PPSP group in the study started with higher average utilization levels because all PPSP enrollees in January 1983 were chosen because they had at least some utilization history and were long-term Medicaid eligibles — two factors not present in the control group.)

Implications

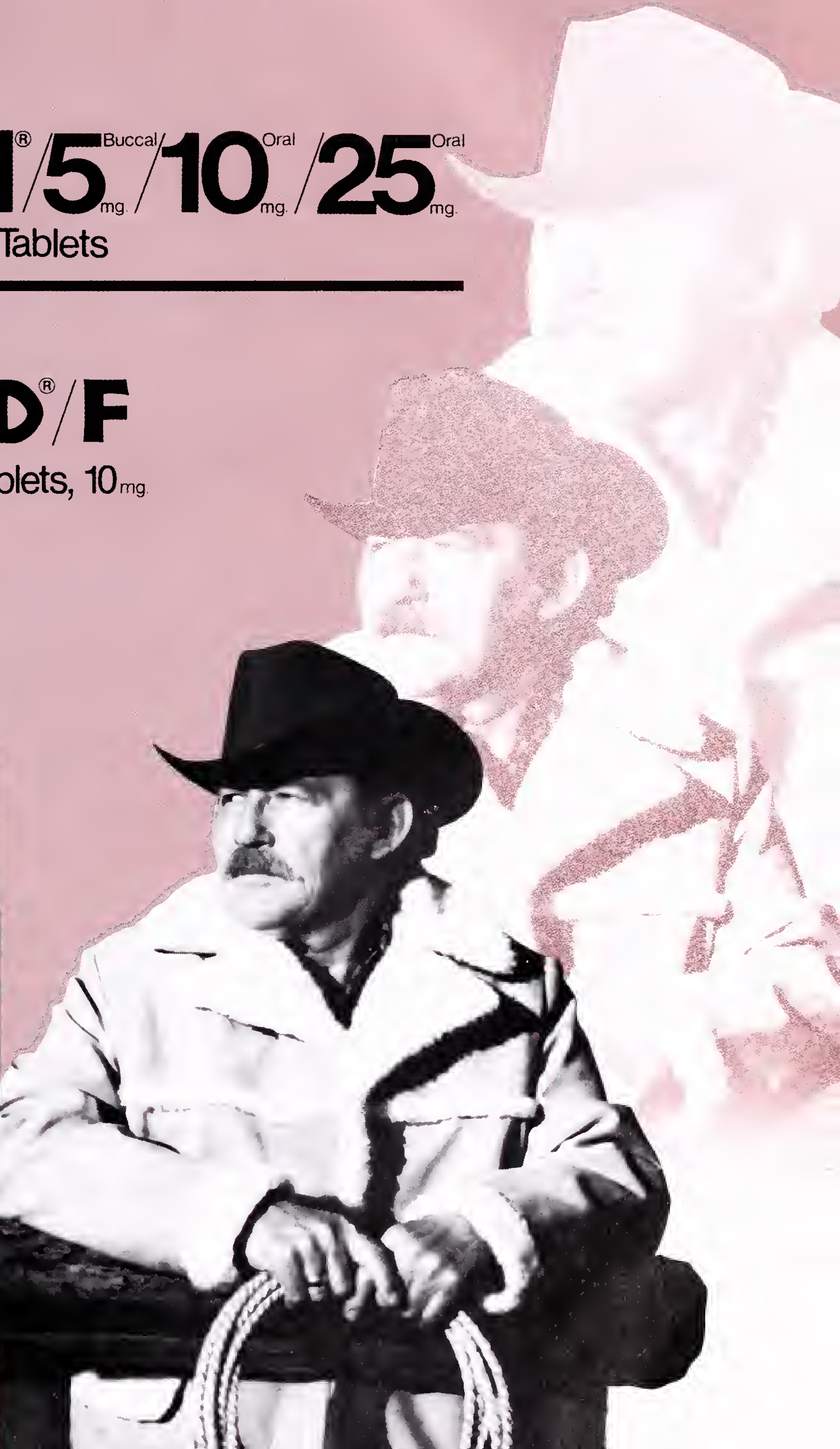
The study's findings are consistent with those of an earlier DSS study of a nonrandom sample PPSP group (the first enrollees in the plan). Although the results must be interpreted with caution, it is now fairly clear that the PPSP is causing change in the desired direction from a cost-effectiveness viewpoint. Because of the margins of error that exist with small sample sizes, however, it is still impossible to say with confidence the exact magnitude of the changes that are occurring. The long-term MDSS study will attempt to establish these changes with greater certainty. Copies of the study described in this article may be obtained by a written request to the Physician Primary Sponsor Plan, Medical Services Administration, P.O. Box 30037, Lansing, 48909.

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

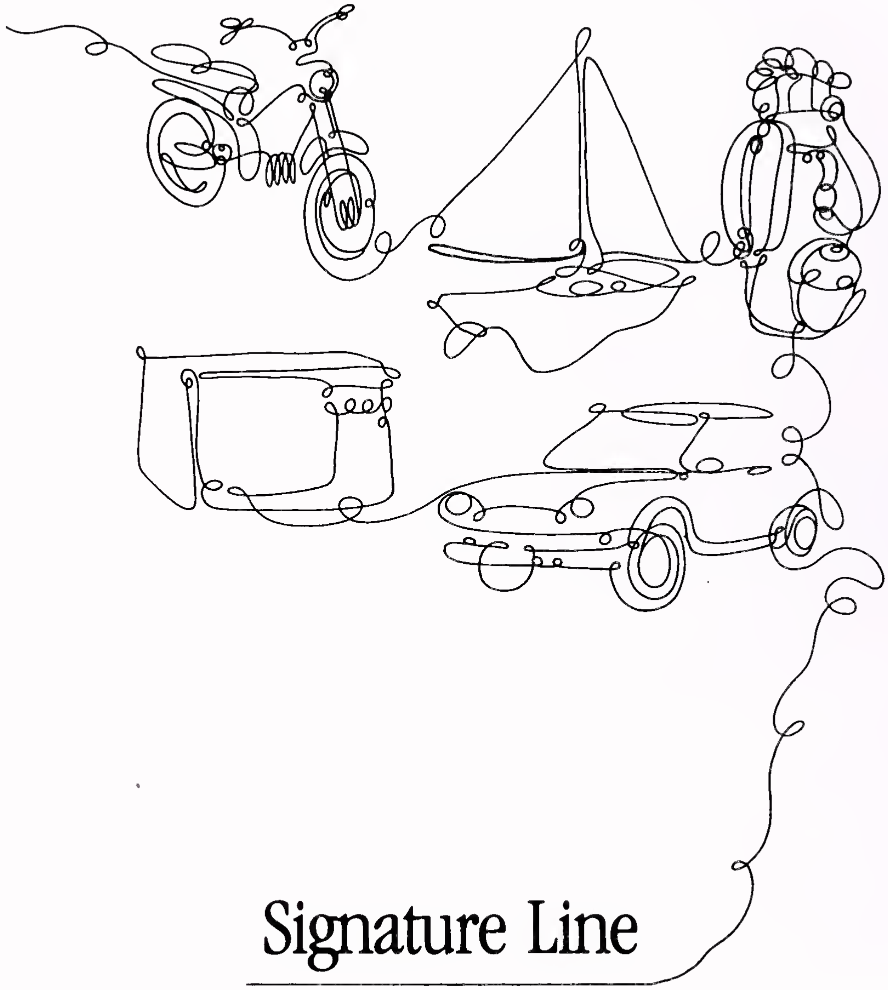
For Full Prescribing Information, Please See PDR. REFER TO PDR

Android® /5 mg. Buccal /10 mg. Oral /25 mg. Oral
Methyltestosterone U.S.P. Tablets

ANDROID® /F
Fluoxymesterone U.S.P. Tablets, 10 mg.



The shortest distance between you and your credit needs:



Signature Line

We'll lay it on the line: you file one credit application. You draw from one line of credit. You use it for anything you want. You make one payment every month or every quarter. It's just what a person of your means needs–and deserves.

We'll lay our rate on the line, too: When your balance is $1,000 or more, you'll pay 2% above prime*. That's lower than most other forms of credit. And no matter how high the prime goes, you won't pay more than 18% APR.

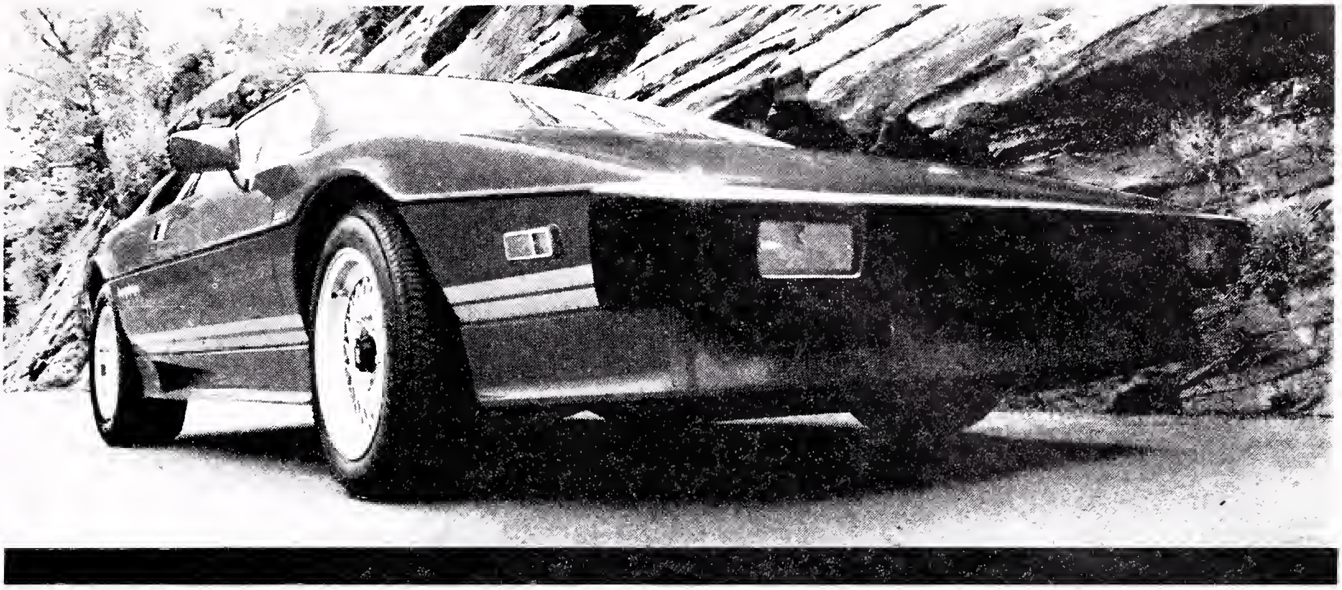
Let's face it. You don't need the bother of completing an application every time you want credit. Don't. Choose the shortest distance between you and your credit needs: Signature Line.

Phone 1-800-632-4453 during normal business hours.

Call Union Bank, toll-free, for a Signature Line brochure and application.

*Signature Line interest rates are based on Union Bank's prime rate. The Annual Percentage Rate may vary from 11.5% to 18% if your average daily balance is over $1,000. If your average daily balance is $1,000 or less, the Annual Percentage Rate (APR) is 18%.

UB UNION BANK
Member FDIC



Earn your stripes

We have . . . on Formula 1 road courses around the world, at Indianapolis where we pioneered rear-engine racing, and in the hands of countless serious driving enthusiasts.

The world of the Lotus Turbo Esprit is a fellowship that lives on the kind of performance, handling and response you just don't find in the dilettante's sports car.

Like everything Lotus does, the Turbo Esprit is a road car to be taken seriously. Its 16-valve turbocharged mid-engine delivers 205 bhp and leaps from 0 to 60 in 6 seconds flat. If you think $50,000 is too much to ask for a genuine legend, turn the page. But if you take your driving seriously, test drive the astonishing Lotus Turbo Esprit soon at Birmingham Motors, Ltd., and see if you've earned your stripes.

LOTUS

Lotus

BIRMINGHAM MOTORS, LTD.

479 S. Woodward, Birmingham MI 48011 (313) 646·3980

By Judith Marr

Michigan physicians their own PPO experts

Most Michigan physicians see a great deal of activity underway in the formation of preferred provider organizations. Most physicians are not sure where this activity is leading, and are not sure they want to jump on the bandwagon now.

If that sounds a little like your own thoughts, then you would agree with the summary of the situation provided by MSMS President Donald K. Crandall, MD, Muskegon, at a recent all-day MSMS conference on "The Basics of PPOs."

Intense interest

The Lansing conference attracted nearly 200 physicians and other persons whose busy note-taking attested to the intense interest in this new health care delivery alternative.

The conference purpose was to give physicians the nuts and bolts of forming a PPO.

"PPOs are one of the most rapidly developing health care delivery alternatives," said Doctor Crandall. "MSMS wants to help physicians position themselves to best take advantage of the new payment systems."

Quipped Doctor Crandall, the variety of organizations coming under the PPO canopy is so great that, "If you've seen one, you've seen one."

We are moving to a multiple-option, decentralized society, he continued. Physicians in the future may have contracts with an HMO and two or three PPOs and still have most of their business on a fee-for-service basis. "But as physicians we ought to understand the trends."

Physicians attending the recent MSMS PPO conference took extensive notes.

If physicians are not willing to address two problems — increased utilization on the physician side, and increased costs on the hospital side, they shouldn't be in a PPO, observed Doctor Crandall.

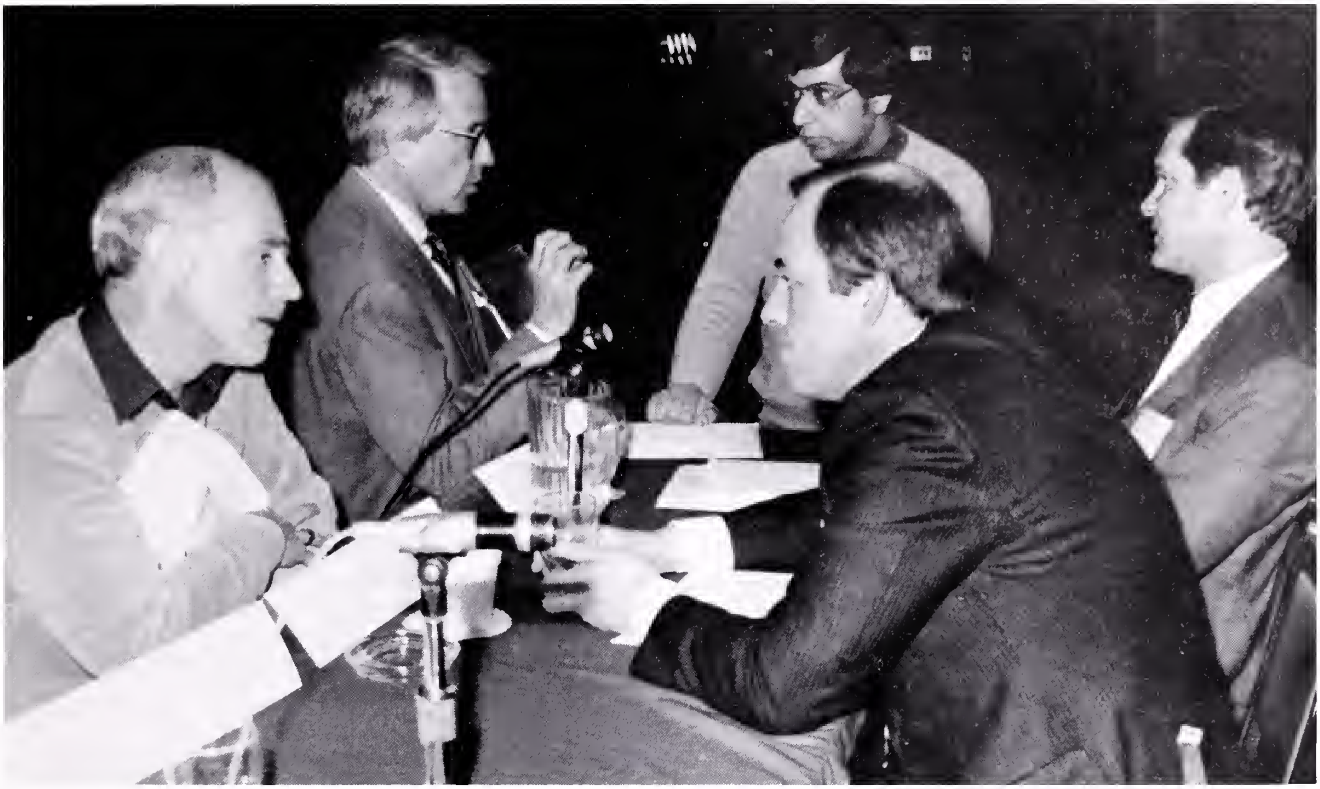
"We are going to have to analyze the situation and make sure our hospitals are efficient," he continued. Hospitals are used less now, he reported, and occupancy rates are down. Their unit price is up, therefore, because 70 percent of their costs are fixed.

Physicians' prices, on the other hand, have lost out on the consumer price index and have dropped from 25 percent of health care costs to 12 to 14 percent. "To make up, we've increased our utilization rates," he said.

The speakers advised the physicians to move cautiously as they formed PPOs, to carefully create goals, then call in legal and accounting experts. They were advised that the time is short to deliberate, as insurance companies and the government are at work now to form their own PPOs and other working arrangements involving physicians' services.

Blue Cross Blue Shield of Michigan, for instance, expects to solicit PPO arrangements in southeast Michigan by midsummer. BCBSM wants to make these PPO type arrangements available to all its members in the state, and believes 25 percent of its subscribers could be covered by PPOs in two years, said Robert Reveley, BCBSM vice president for health care affairs.

PPOs may be a rather short-lived phenomenon, observed



Following the afternoon's panel session, some intense question/answer sessions resulted. Around the speaker's table above are, from left, William Bernard, MD, Flint; keynote speaker Manford M. Oliphant, Jr., MD; Devendra Sharma, MD, Tawas City, rear; speaker Robert Asmussen, Henry Ford Hospital, and speaker Monte Jahnke, MSMS legal counsel.

several speakers, among them Mr. Reveley: "PPOs may only be around a few years until people get acclimated to more limited access to care."

DRG Impact

More than one speaker expressed concern that physicians might be jumping too soon to form PPOs.

Robert Asmussen, senior consultant with Henry Ford Hospital, observed that he thinks there is too much interest in PPOs. "We may be going overboard on this concept, especially in Michigan," he said.

Of much greater impact, he said, will be the federal government's implementation of the diagnostic related group (DRG) reimbursement system. "This not only has immediate impact," he continues, "but also leads to their future case cap strategy.

Continued on page 242

B. David Wilson, MD, Kalamazoo, left, and E. Joseph Alberding, MD, Portage, listened intently to the program.

Washington is very anxious to include physician and hospital services in that strategy."

Asmussen observed that the federal action toward DRGs has had "enormous impact" on the private sector, which he sees reacting with self-insurance arrangements, changes in health care benefit packages away from first-dollar coverage, and other third party activity.

The reaction of the health care delivery system to government initatives, he said, has been a dramatic increase in HMO enrollment.

"Employers are adjusting their benefit packages, reducing their contributions. This will lead to further HMO enrollment.

"Every hospital and physician is trying to figure what to do," he continued, "and too many are emotionally reacting, not moving carefully."

Asmussen said he does not believe physician-founded PPOs will be as easy to market as those formed by hospitals and physicians together. "Individual physicians do not carry the same reputations as quality institutions in the community."

He thinks the joint venture strategy seems to work best, as "it creates the right environment and working atmosphere."

Structuring PPOs to make them attractive will be the biggest problem in our area, predicted Mr. Asmussen. "Consumers will go where they get the most benefits for the least out-of-pocket expense."

There is a market for the PPO in Michigan, he said, though he says it is going to be relatively small.

"Unless PPOs (provide) the opportunity to contain utilization of health services, HMOs are going to eat them alive," he said. He suggested interested persons start by developing a model consistent with the traditional PPO.

Like HMOs

The theme that PPOs may end by being more like HMOs was another reiterated by speakers during the day.

Frederick VanDuyne, MD, instrumental in a Flint-area PPO, commented during a question-answer period that "the only PPOs which will succeed are the ones which adopt HMO-type controls and adopt risk-sharing of all providers. We see PPOs going closer to HMOs."

Speaker E. Joseph Alberding, MD, Kalamazoo, agreed with the above, predicting that we will see systems made up of groups of providers working within organizations contracting to PPOs. Doctor Alberding suggested that "we physicians have been working in these PPOs all the time."

"We've had organizations of 'preferred providers' who have unofficially referred patients to MDs they preferred, based on the patients' needs and the physicians' knowledge of their fellows' competence.

Doctor Alberding, a prominent member of the Kalamazoo Area Physicians Association, a PPO-in-process, continued that he views the "new PPO" as one based on economics, which can be used to control medical practice by economic means.

Mountain Medical

The nation's most experienced PPO — the three-year-old Mountain Medical Affiliates of Denver — has successfully tackled those problems, reported MMA President Manford M. Oliphant, Jr., MD, in the morning's keynote talk.

MMA has cut the average length of stay for its patients by one day, while increasing total hospital admissions 35 percent and numbers of patients 30.5 percent. The PPO has effected $4.1 million in savings, cutting average costs per day from $635 to $532. Denver-area employers now save 14 to 18 percent per year with their participating employees, due to improved utilization rates and a discount deductible system.

MMA shares 23 area contracts with three other PPOs in Denver, serving 70,000 of a potential 150,000 population. It is a joint venture that provides Doctor Oliphant with five to eight percent of his income.

"The PPO works if the situation is favorable and the participants are cost-effective," said Doctor Oliphant.

A PPO, he said, ought to be autonomous, have wide geographic dispersion of physicians and/or hospitals in the area, allow continuation of office practices, continue the fee for service payment system, provide a competitive, uniform fee structure, have self-maintained utilization and peer review and be independent of the hospital.

He stressed the importance of review and modification of physicians' practices to effect cost containment.

MMA has made mistakes, he acknowledged. "But fortunately we started small and simply, and have not really suffered." MMA officers now are reorganizing their structure so that it will be more efficient, with more teeth in it, and with less anti-trust vulnerability, he said.

No experts

Lawyer Monte Jahnke of the MSMS counseling firm Kerr, Russell and Weber of Detroit, emphasized that physicians' considerations preliminary to forming a PPO are particularly important. "You must understand the structure before you get underway," he said. "Note the makeup of the group, look at market forces and do your best to understand how a PPO will affect you personally.

"Look at your personal goals and try to take a long-range perspective," he continued. "Then spend your legal fees and account fees and get expert help ASAP.

So where does the interested Michigan physician find knowledgeable outsiders when, as Doctor Crandall noted, "PPOs have no track record in Michigan?"

"There are no experts," answered Doctor Alberding. "We have to create a panel of our own. That's why we're here — to help each other judge whether we have experts or charlatans dealing with us."

Competence counts

Hurley Medical Center photo

In selecting a doctor, 74 percent of Americans consider competence, not cost.

Competent doctors remain the key to health. But competence isn't immunity to litigation.

Consider our competence – and our professional liability protection and strong-defense philosophy.

We defend you against non-meritorious claims. We won't settle a claim without your approval or merely to cut our defense cost.

PICOM
Physicians Insurance Company Of Michigan
4277 Okemos Rd., Box 1000
Okemos, Michigan 48864

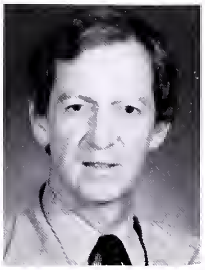
(517) 349-6500
(313) 557-4845
1-800-292-1036

By Joyce Crum

Davies

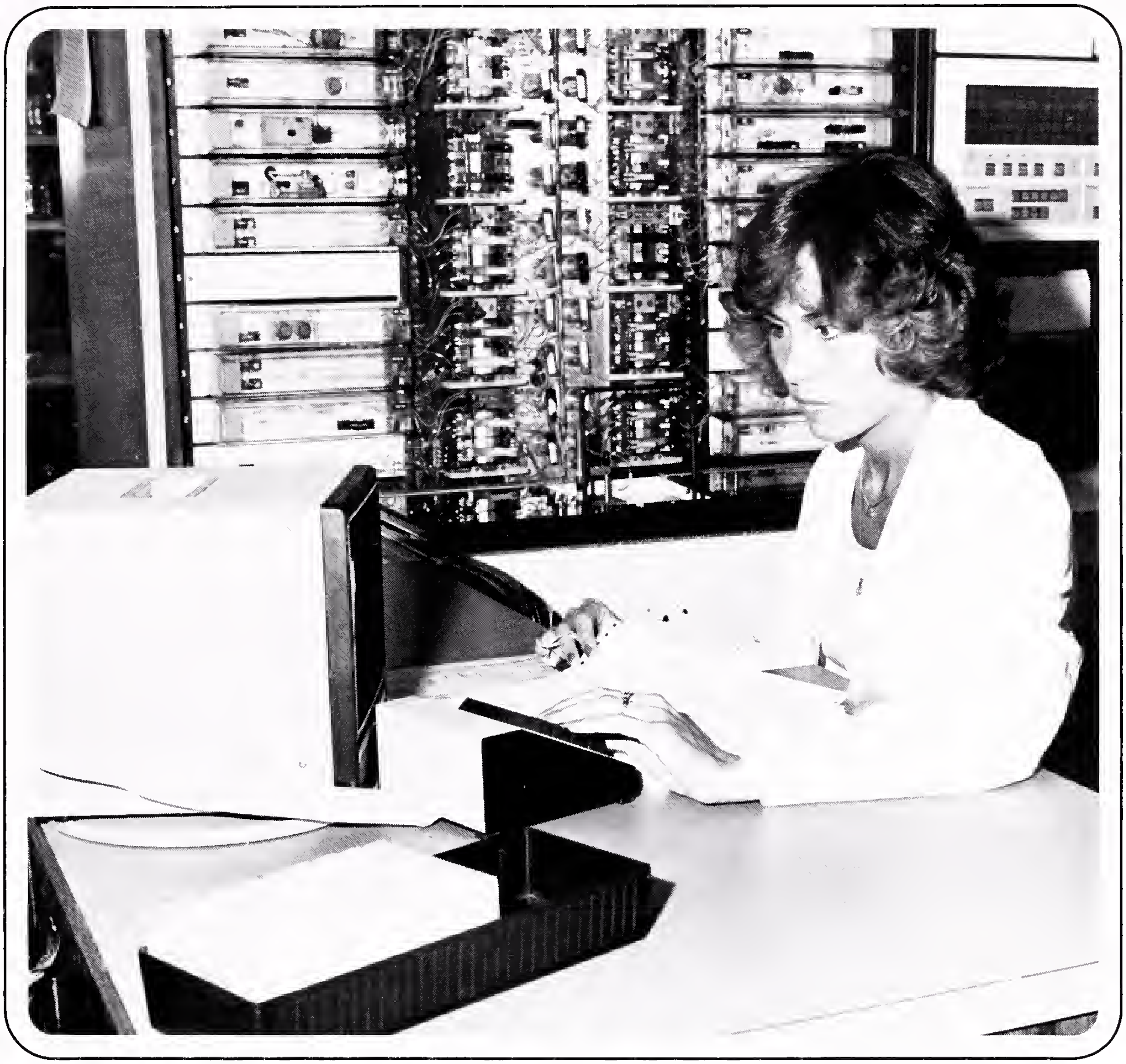
Leitch

Rovner


Veldman

David R. Rovner, MD, East Lansing, is recipient of the Distinguished Faculty Award from Michigan State University for his exemplary performance, not only in the classroom, but in the clinical setting in which he practices. Doctor Rovner is chairman of the Planning Committee for MSMS Annual Scientific Meeting ... The "singing surgeon," **Yvan Silva, MD,** Detroit, has just released his second album of romantic ballads entitled "Talk to Me." Doctor Silva's musical accomplishments, combined with his medical career, have made him the subject of several features in local and national publications lately. ... Sinai Hospital of Detroit Board of Trustees has named **Arnold R. Axelrod, MD,** Detroit, vice president of medical affairs. Succeeding Doctor Axelrod as chairman of the Department of Medicine is **Melvyn Rubenfire, MD,** Detroit. ... **Eugene Otlewski, MD,** Southfield, is the new president of Providence Hospital medical staff. ... **Dennis Wagner, MD,** Sanford, has received the Jefferson Award for his years of service to the Midland area. Doctor Wagner serves on the MSMS Committee on Child Abuse and is active in Midland County child-abuse prevention efforts. ... The March 19, 1984 Medical Economics issue features an article by **Robert M. Leitch, MD,** East Lansing, entitled "There are six basic steps to avoiding a malpractice suit." Doctor Leitch is current secretary and past president of MSMS. He is current president of the Michigan Physicians Mutual Liability Company. ... Effective July 1, **June E. Osborn, MD,** Ann Arbor, will be the new dean of University of Michigan's School of Public Health. Doctor Osborn is currently professor of medical microbiology and pediatrics in the Wayne State University School of Medicine. ... **Edward Pearce, MD,** Northville, has been appointed the chief-of-staff of St. Mary Hospital in Livonia. ... **Jerold P. Veldman, MD,** Lansing, is joining the hospital medical staff at the Regional Center for Development Disabilities in Coldwater. Doctor Veldman has been a pediatrician in the Lansing area for the past several years. ... Newly elected as chief of the medical staff at Leila Hospital and Health Center for 1984 and 1985 is **William B. Comai, MD,** Battle Creek. Doctor Comai has practiced medicine in Battle Creek since 1968. ... Memorial Medical Center announces the appointment of **Kathleen Sazama, MD,** Ludington, as director of clinical laboratories. Doctor Sazama will succeed **Christie Davis, MD,** who is retiring. ... The American Academy of Forensic Sciences honored **Emanuel Tanay, MD,** Detroit, with its 1984 Psychiatry Award during their annual meeting. George E. Gantner, MD, president of the Academy described Doctor Tanay as "one of the most in-demand, ever-interesting speakers in the Academy, and a professional of international acclaim." ... **Robert M. Lugg, MD,** Port Huron, has been named Public Citizen of the Year by the St. Clair County Unit of the Michigan Chapter, National Association of Social Workers. Doctor Lugg was cited for outstanding leadership in advancing the quality of, and enlisting public support for, human services in the community. ... **Ramon Berguer, MD,** West Bloomfield, and **Raymond B. Bauer, MD,** Grosse Pointe, are editors of a book entitled, "Vertebrobasilar Arterial Occlusive Disease: Medical and Surgical Management," published recently. ... **John H. Williams, MD,** Detroit, was elected president of the medical staff of Cottage Hospital of Grosse Pointe for 1984. ... The Michigan Health Council has elected **Terence Davies, MD,** Ann Arbor, chairman of the Department of Family Practice at the University of Michigan Medical School, to serve on the MHC Board of Trustees. ...

Ms. Crum is secretary to *Michigan Medicine.*



Technicon Smac

General Chemistry: Advance Medical & Research Center, Inc., employs the latest in sophisticated automation in the performance of routine blood chemistry determinations. This allows for the greatest consistency in quality assurance of results while utilizing the least amount of patient specimen.

ADVANCE MEDICAL & RESEARCH CENTER, INC.

1270 Doris Rd. • Pontiac, Michigan 48057 • (313) 373-9120

Branches: Allen Park, Alpena, East Jordan, Flint,
Grand Rapids, Kalamazoo, Lansing, Monroe, Traverse City

Serving the medical profession since 1963

YOU'RE NOT ONLY OUT

And you can be even farther out front with a tailor made financial planning instrument from Life of Virginia.

As a discerning professional, you give considerable thought to a variety of decisions that effect your financial security: flexibility, performance, and tax treatment to name just a few.

Now all of those elements are available in one package from the industry leader. Fundamentals such as:

Flexibility. Premium payments that can be increased or decreased or skipped altogether, depending on your needs.

Performance. Universal life products that credit current, competitive interest rates on cash values over $1000.*

Favorable tax treatment. Products that enjoy the tax preferences you get from any life insurance policy, as confirmed by the 1982 Tax Bill.

Adaptability. Coverage that can be adjusted up or down to meet changing needs, without adding new policies or canceling old ones.

Utility. Policies that offer such a wealth of possibilities that each comes with a Buyer's Manual to help you take full advantage of their features.

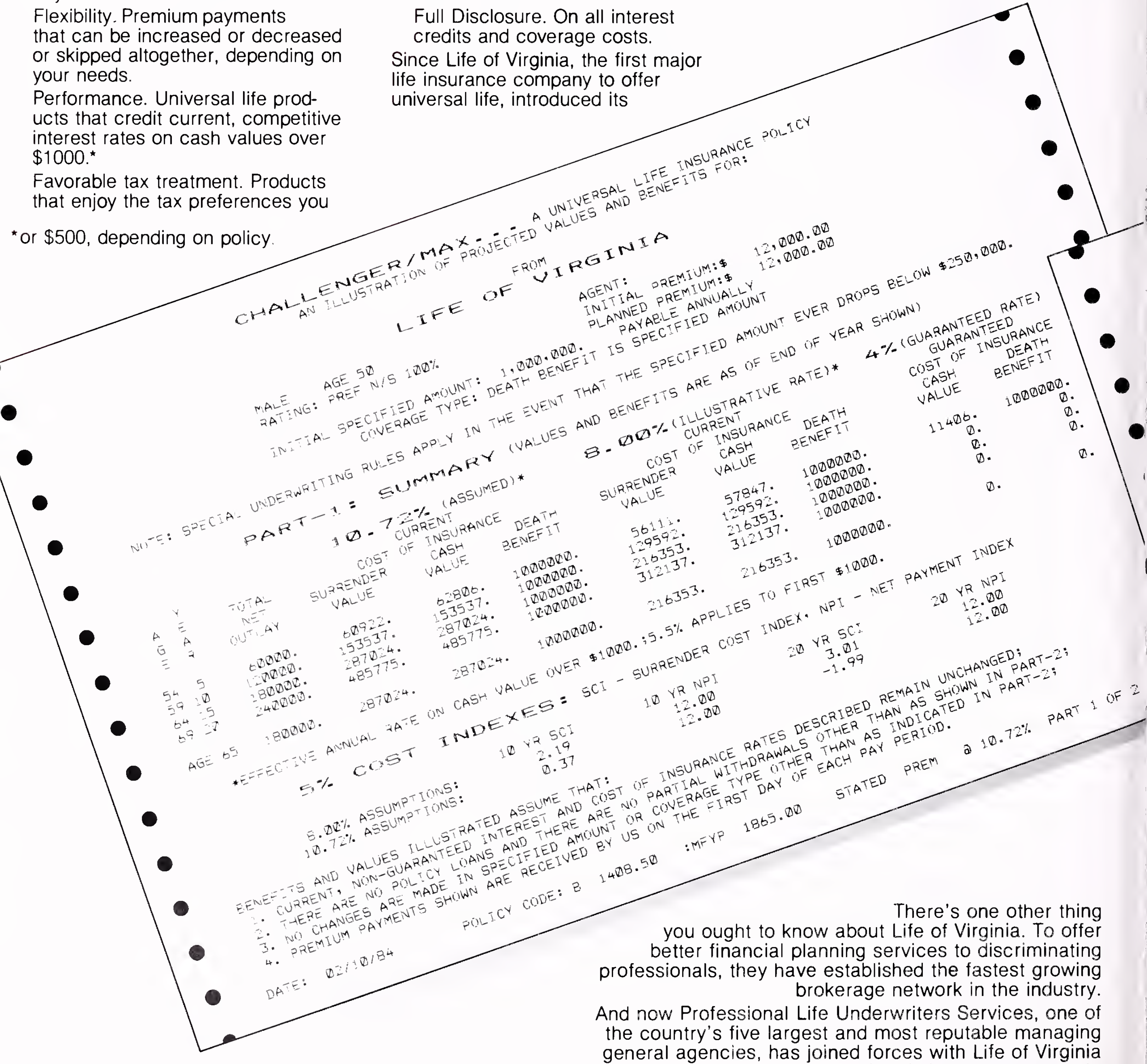
Full Disclosure. On all interest credits and coverage costs.

Since Life of Virginia, the first major life insurance company to offer universal life, introduced its Challenger policy, market acceptance has driven sales to successive records.

And Life of Virginia has stayed in front by:

—pioneering the Dual Rate Index^{SM} to give consumers maximum interest yields.

—offering the broadest universal life product portfolio in the industry.



```
CHALLENGER/MAX- - - A UNIVERSAL LIFE INSURANCE POLICY
   AN ILLUSTRATION OF PROJECTED VALUES AND BENEFITS FOR:
                     FROM
            LIFE  OF  VIRGINIA
                                AGENT:
                                INITIAL  PREMIUM:$        12,000.00
                                PLANNED PREMIUM:$         12,000.00
                                  PAYABLE ANNUALLY
MALE          AGE 50
RATING:  PREF N/S 100%
INITIAL SPECIFIED AMOUNT:  1,000,000.
         COVERAGE TYPE: DEATH BENEFIT IS SPECIFIED AMOUNT
NOTE: SPECIAL UNDERWRITING RULES APPLY IN THE EVENT THAT THE SPECIFIED AMOUNT EVER DROPS BELOW $250,000.
      PART—1 :  SUMMARY  (VALUES AND BENEFITS ARE AS OF END OF YEAR SHOWN)
             10.72% (ASSUMED)*            8.00%(ILLUSTRATIVE RATE)*      4%(GUARANTEED RATE)
               CURRENT                       CURRENT                     GUARANTEED
          COST OF INSURANCE             COST OF INSURANCE            COST OF INSURANCE
A  Y   TOTAL   SURRENDER  CASH     DEATH     SURRENDER  CASH     DEATH      CASH     DEATH
G  E   NET     VALUE      VALUE    BENEFIT   VALUE      VALUE    BENEFIT    VALUE    BENEFIT
E  A   OUTLAY
   R
54  5   60000.  60922.    62806.  1000000.   56111.    57847.  1000000.   11406.  1000000.
59 10  120000. 153537.   153537.  1000000.  129592.   129592.  1000000.      0.        0.
64 15  180000. 287024.   287024.  1000000.  216353.   216353.  1000000.      0.        0.
69 20  240000. 485775.   485775.  1000000.  312137.   312137.  1000000.      0.        0.
AGE 65 180000. 287024.   287024.  1000000.  216353.   216353.  1000000.      0.        0.
*EFFECTIVE ANNUAL RATE ON CASH VALUE OVER $1000.;5.5% APPLIES TO FIRST $1000.
    5% COST INDEXES:  SCI - SURRENDER COST INDEX, NPI - NET PAYMENT INDEX
                       10 YR SCI    10 YR NPI    20 YR SCI    20 YR NPI
8.00% ASSUMPTIONS:       2.19        12.00         3.01        12.00
10.72% ASSUMPTIONS:      0.37        12.00        -1.99        12.00
BENEFITS AND VALUES ILLUSTRATED ASSUME THAT:
1. CURRENT, NON-GUARANTEED INTEREST AND COST OF INSURANCE RATES DESCRIBED REMAIN UNCHANGED;
2. THERE ARE NO POLICY LOANS AND THERE ARE NO PARTIAL WITHDRAWALS OTHER THAN AS SHOWN IN PART-2;
3. NO CHANGES ARE MADE IN SPECIFIED AMOUNT OR COVERAGE TYPE OTHER THAN AS INDICATED IN PART-2;
4. PREMIUM PAYMENTS SHOWN ARE RECEIVED BY US ON THE FIRST DAY OF EACH PAY PERIOD.
              POLICY CODE: B   1408.50   :MFYP   1865.00     STATED   PREM   @ 10.72%   PART 1 OF 2
DATE:  02/10/84
```

There's one other thing you ought to know about Life of Virginia. To offer better financial planning services to discriminating professionals, they have established the fastest growing brokerage network in the industry.

And now Professional Life Underwriters Services, one of the country's five largest and most reputable managing general agencies, has joined forces with Life of Virginia in this brokerage network.

*or $500, depending on policy.

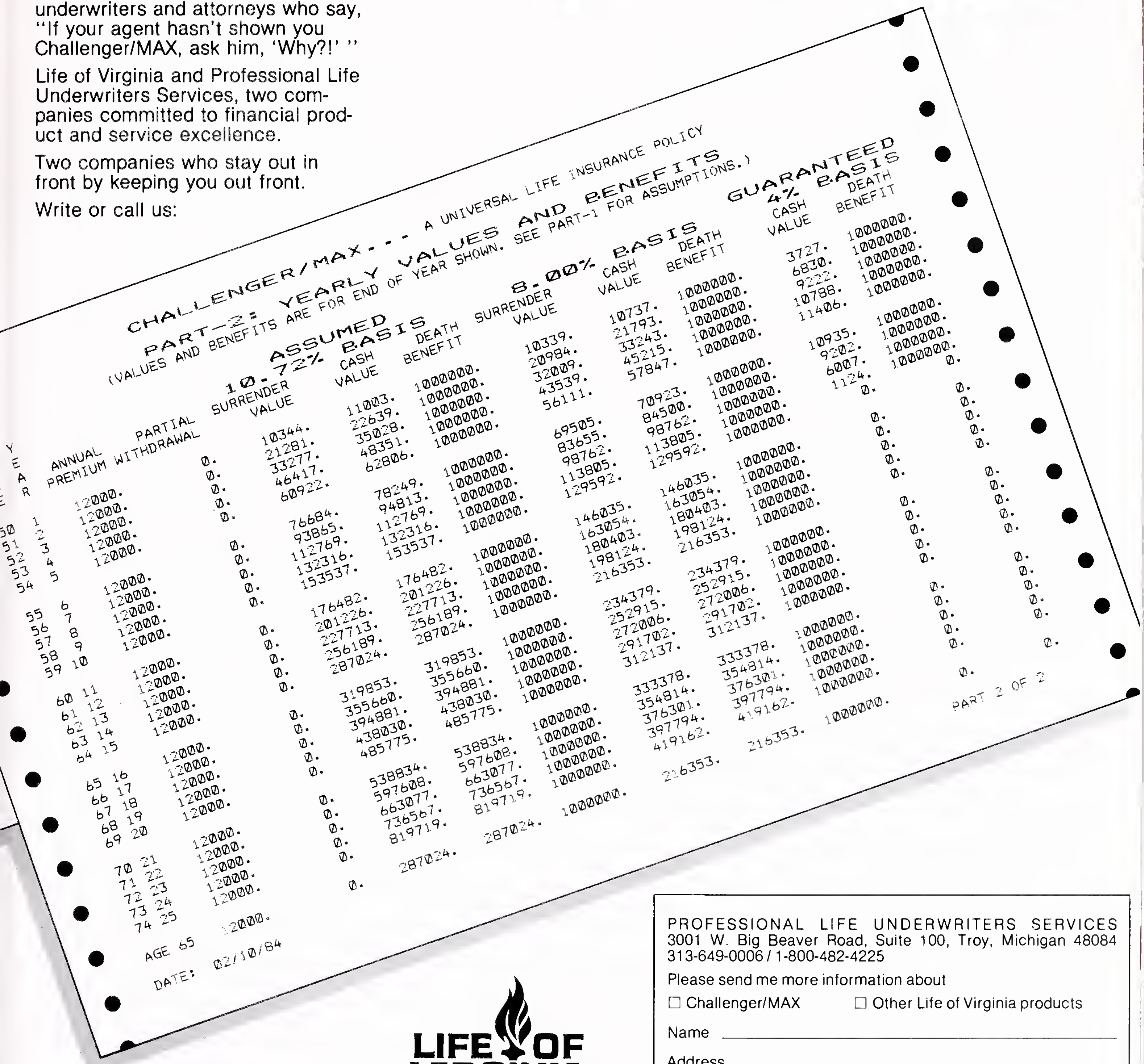
FRONT, YOU'RE PULLING AWAY

Together we offer incredibly competitive products like Challenger/MAX. Take a long look at the illustration shown here and see if you don't agree with the accountants, underwriters and attorneys who say, "If your agent hasn't shown you Challenger/MAX, ask him, 'Why?!' "

Life of Virginia and Professional Life Underwriters Services, two companies committed to financial product and service excellence.

Two companies who stay out in front by keeping you out front.

Write or call us:



CHALLENGER/MAX--- A UNIVERSAL LIFE INSURANCE POLICY

PART-2: YEARLY VALUES AND BENEFITS

(VALUES AND BENEFITS ARE FOR END OF YEAR SHOWN. SEE PART-1 FOR ASSUMPTIONS.)

				ASSUMED 10.72% BASIS			8.00% BASIS		GUARANTEED 4% BASIS	
AGE	YEAR	ANNUAL PREMIUM	PARTIAL WITHDRAWAL	SURRENDER VALUE	CASH VALUE	DEATH BENEFIT	SURRENDER VALUE	CASH VALUE	DEATH BENEFIT	CASH VALUE	DEATH BENEFIT
50	1	12000.	0.	10344.	11003.	1000000.	10339.	10737.	1000000.	3727.	1000000.
51	2	12000.	0.	21281.	22639.	1000000.	20984.	21793.	1000000.	6830.	1000000.
52	3	12000.	0.	33277.	35028.	1000000.	32009.	33243.	1000000.	9222.	1000000.
53	4	12000.	0.	46417.	48351.	1000000.	43539.	45215.	1000000.	10788.	1000000.
54	5	12000.	0.	60922.	62806.	1000000.	56111.	57847.	1000000.	11406.	1000000.
55	6	12000.	0.	76684.	78249.	1000000.	69505.	70923.	1000000.	10935.	1000000.
56	7	12000.	0.	93865.	94813.	1000000.	83655.	84500.	1000000.	9202.	1000000.
57	8	12000.	0.	112769.	112769.	1000000.	98762.	98762.	1000000.	6007.	1000000.
58	9	12000.	0.	132316.	132316.	1000000.	113805.	113805.	1000000.	1124.	1000000.
59	10	12000.	0.	153537.	153537.	1000000.	129592.	129592.	1000000.	0.	0.
60	11	12000.	0.	176482.	176482.	1000000.	146035.	146035.	1000000.	0.	0.
61	12	12000.	0.	201226.	201226.	1000000.	163054.	163054.	1000000.	0.	0.
62	13	12000.	0.	227713.	227713.	1000000.	180403.	180403.	1000000.	0.	0.
63	14	12000.	0.	256189.	256189.	1000000.	198124.	198124.	1000000.	0.	0.
64	15	12000.	0.	287024.	287024.	1000000.	216353.	216353.	1000000.	0.	0.
65	16	12000.	0.	319853.	319853.	1000000.	234379.	234379.	1000000.	0.	0.
66	17	12000.	0.	355660.	355660.	1000000.	252915.	252915.	1000000.	0.	0.
67	18	12000.	0.	394881.	394881.	1000000.	272006.	272006.	1000000.	0.	0.
68	19	12000.	0.	438030.	438030.	1000000.	291702.	291702.	1000000.	0.	0.
69	20	12000.	0.	485775.	485775.	1000000.	312137.	312137.	1000000.	0.	0.
70	21	12000.	0.	538834.	538834.	1000000.	333378.	333378.	1000000.	0.	0.
71	22	12000.	0.	597608.	597608.	1000000.	354814.	354814.	1000000.	0.	0.
72	23	12000.	0.	663077.	663077.	1000000.	376301.	376301.	1000000.	0.	0.
73	24	12000.	0.	736567.	736567.	1000000.	397794.	397794.	1000000.	0.	0.
74	25	12000.	0.	819719.	819719.	1000000.	419162.	419162.	1000000.	0.	0.
AGE 65		12000.	0.	287024.	287024.	1000000.	216353.	216353.	1000000.	0.	0.

DATE: 02/10/84

PART 2 OF 2

LIFE OF VIRGINIA

Professional Life Underwriters Services

3001 W. BIG BEAVER RD.
SUITE 100
TROY, MICH. 48084

PROFESSIONAL LIFE UNDERWRITERS SERVICES
3001 W. Big Beaver Road, Suite 100, Troy, Michigan 48084
313-649-0006 / 1-800-482-4225

Please send me more information about

☐ Challenger/MAX ☐ Other Life of Virginia products

Name ______________________

Address ______________________

City ______________________

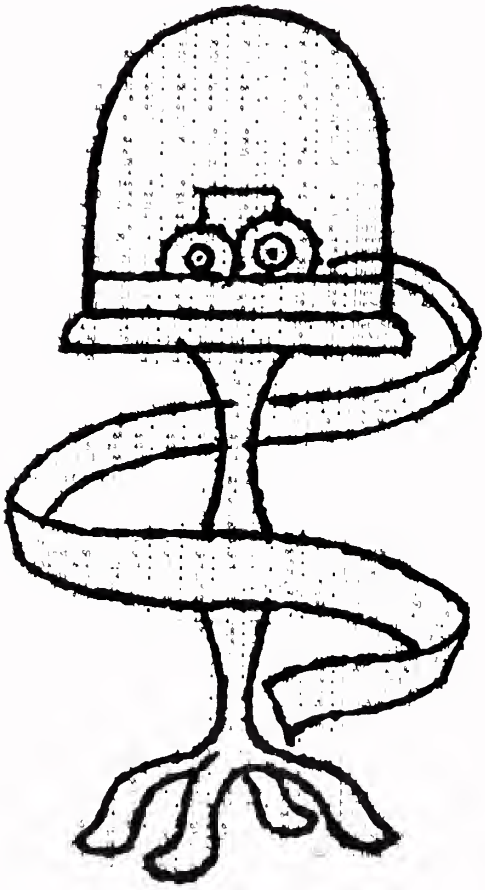
State ______________________

Phone Number ______________________

Date of Birth ______________________

By Katharine S. Brown

The dynamics of municipal bonds



Municipal bonds offer diversification in the broadest sense of the word.

The single most important feature of municipal bonds is tax exemption. Interest earned on municipals is free from federal income taxes and, generally, from taxes of the state in which the bonds are issued. With an increased Michigan income tax, Michigan tax-free bonds offer you an opportunity for income free from federal and state taxation.

Municipal bonds are issued by local governments (cities, states, and various districts and political subdivisions) instead of the federal government and its agencies.

Yields on municipal issues are determined by the current level of interest rates, the credit rating of the issuer, and the tax laws.

Interest is normally paid semiannually. Investors tend to buy them as they are issued and hold them until maturity. However, municipals, like other bonds, can be sold prior to maturity in the secondary market at the prevailing market rates.

In terms of safety, tax-exempt bonds are second in security only to United States government securities. Even during the depths of the great depression only about two percent of outstanding municipal issues defaulted. And the vast majority of those were subsequently cleared up without loss of principal and interest. This fine record continues today, in spite of the difficulties experienced by New York City and more recently, Washington Public Power.

Should you invest in municipal bonds? When I am asked that question, my answer is, "It depends on what you are going to do with the money if you do not." If you are planning to put it into a savings account at five-and-one-half percent or a corporate bond at nine percent, and you are in a 43 percent bracket, you can see from the tax equivalents (table below), you would receive more real income from municipal bonds. As you will note, you would have to receive a taxable rate of 15.79 percent to equate the nine percent tax-exempt income rate in the 43 percent bracket; and in the 49 percent bracket, you would need to receive a 17.65 percent taxable yield to be equivalent to nine percent tax exempt.

Tax Bracket	Nine Percent Municipal Bond Equivalent to a Taxable
30%	12.86%
35%	13.85%
37%	14.29%
43%	15.79%
49%	17.65%
50%	18.00%

Municipal bonds offer diversification, marketability and a wide selection of maturities. In some situations, they also feature insurance guaranteeing the timely payment of principal and interest.

Ms. Brown is an account executive with Prescott, Ball and Turben, investment banks and brokers, East Lansing. She is consultant to the MSMS Board of Managers on the investment of the MSMS capital and creative reserve funds assets.

Diversification

Municipal bonds offer diversification in the broadest sense of the word. Geographically, literally thousands of communities, as well as virtually all the states, enter the market for funds each year. This allows the investor to select issues that suit his requirements for quality, yield and additional tax benefits (where states exempt local bonds' interest from State income taxes).

Marketability

Municipal bonds have always enjoyed good marketability. In recent years, however, under pressure of record volumes of new issues, there has been a pronounced development in the distributive channels for municipals, resulting in a further broadening of this market. The evolution of communication in the municipal field similarly has reached a point where, through telephone and wire systems, brokers and dealers are virtually in constant touch with each other, producing a nationwide market for your bonds on an instant's notice.

Maturities selection

Most municipal and state obligations are scheduled to mature over a period of years, enabling the borrowing communities to spread the tax burden, so that subsequent as well as current users of the new facilities will share the construction cost. This feature is a boon to the investor who may wish to put his money to work for a specific period of time. The investor may obtain maturities that suit his estate building or educational plans, or for retirement purposes. An illustration of this feature is the man who wished to set aside funds to provide for his son's college education. This investor purchased municipals maturing when the money was needed.

Insurance protection

Municipal bonds are unique in that insurance is available which provides that if the issuer fails to pay interest and principal when due, the holder can present such matured interest coupons and/or bonds to the insurer and obtain payment.

If you want to select your own bond portfolio, it will be essential for you to learn something about quality ratings. If you are letting the professionals select them through municipal bond funds or trust, a knowledge of ratings will still be helpful as you study their portfolios. Moody's Investor Service and Standard and Poor each rate municipal bond obligations according to relative investment qualities.

Types of bonds

Individual municipal bonds fall into three main categories:

Full faith and credit bonds (general obligation) of a state or political subdivision of the state have the full taxing power of the issuing local government available to pay both the principal and the interest. **Special tax bonds** have a designated tax (gasoline, liquor, cigarettes) specifically pledged to pay the interest and principal. **Revenue bonds** are backed by the earnings generated in a particular facility and do not have the taxing power of a local government upon which to draw. Many of these bonds are of a very high quality and are often rated equal to or higher than some bonds backed by taxes.

Industrial revenue bonds have also appeared in recent years. These bonds generally are secured by a corporation that has entered into a lease agreement with a community. The bond issuer is normally a public authority that issues the bonds under its municipal title but receives annual installments sufficient to pay the principal and interest on the bonds from the corporation that is using the facility.

Trust funds

If tax-free income fits your financial plans but you do not have the expertise to select, the time to supervise, or sufficient funds to diversify, you may want to consider investing in a municipal bond trust fund. They are usually sold in units of $1,000, plus accrued interest to settlement date. Most of them contain a well-selected diversified portfolio and a tax-exempt yield, which they will pay to you on a monthly, quarterly or semiannual basis. The funds are closed-end and self-liquidating, and usually do not carry a management fee (because they are not managed), though a nominal sales charge of around three-and-one-half percent is charged when they are purchased. Although the sponsors are usually not required to do so, they do make a secondary market in the trust, thereby giving you liquidity if you should so desire.

The Tax Reform Act of 1976 made it possible for brokers to also offer municipal bond funds. These are managed funds that allow additions of smaller amounts of money; a check a month; and the various other conveniences of a regular mutual fund, such as redemption at net asset value, reinvestment of distribution, etc. The municipal bond trust places bonds in a portfolio where they remain until maturity. The bond funds have professional managers who buy and sell bonds in an attempt to maximize yield and safety.

One of the advantages of bonds is their ease of liquidation. Remember, however, liquidation price depends on where current interest rates are in respect to the interest yield on the bonds in your portfolio.

As with all investments — diversification is the key — particularly with respect to the maturity dates.

By Betty Drew

MSMS Auxiliary gains members

"a year for children"

As I view the MSMS Auxiliary's activities of the last 11 months, I feel meaningful contributions in several areas have been made.

Our participation in Michigan's Second Annual Organ Donation Awareness Week, April 22-28, was on a larger scale than last year.

Auxilians distributed attractive new brochures to physicians' offices, pharmacies, libraries and hospitals throughout the state. In southeast Michigan, on April 8, two TV stations each carried a 30 minute program on organ donation, including interviews with local organ recipients. One of the foremost transplant surgeons in Michigan spoke at our MSMS/A Annual Session.

Many of our county auxiliaries emphasized child abuse, its identification and reporting, during the year. At our Annual Session we previewed a lively, sensitive drama to teach children to recognize and report sexual abuse.

Our MSMS Auxiliary has purchased the film, "One for My Baby" dealing with fetal alcohol syndrome. It has been used by several county auxiliaries to inform their members on this preventable cause of birth defects.

The AMA Education and Research Fund (AMA-ERF) has again offered a challenging opportunity to medical society and auxiliary members to contribute those vital monies for use by the medical schools. The deans of the three Michigan medical schools were present at our Annual Session May 14-16 to receive yearly checks from MSMS Auxiliary. An auction on May 15 augmented this fund, the result of contributions from county medical societies and auxiliaries throughout the state.

Membership gains in the members-at-large category have been exciting. We explored resident physician spouse membership, and more emphasis on aiding and attracting these potential future auxilians is on the agenda for next year. We have increased our state membership by 59 members, to a total of 2,394 members.

Each Auxilian has had the opportunity this year to be the best informed member of the family on current medical legislative issues, due to the diligent work of our Legislative Committee. Innovative "bill of the month" summaries sent to each county auxiliary have discussed the professional liability omnibus bill, adult seat belt requirements, optometry and chiropractic expanded scope of practice, regulation and licensing procedures for weight loss clinics, prudent purchaser agreements, parental consent waiver for prenatal and pregnancy related medical services and immunity of state Board of Medicine members. Increased attendance at Legislative Day reflects auxilians' interest.

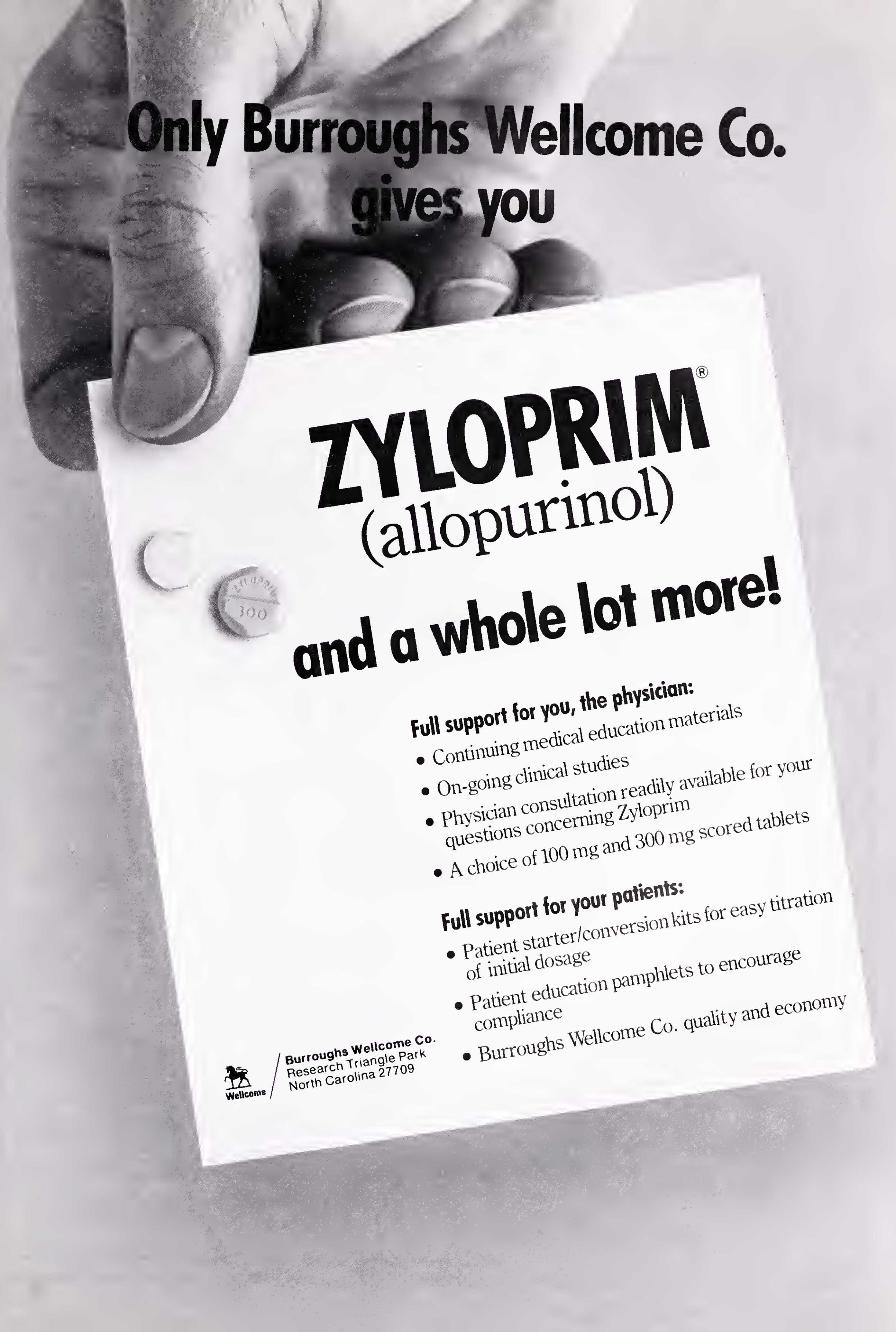
The compilation of our standing rules and policy statements in a single document has been accomplished this year. The special committee chaired by President-elect Nancy Crandall is reviewing fiscal policy, communication with MSMS and its staff and the use of *Michigan Medicine* as an information source to both physician and spouse.

MSMS/A committees are expanding to reflect the members' expertise and interest in bringing health information to their communities.

It has been a year of exhilaration for me, as president, to see dreams become reality.

I will always treasure the friendship, individual style and commitment of your spouses as together we have tried to make this a better "Year for Children."

Mrs. Drew, of Bloomfield Hills, is 1983-84 MSMS/A president.



Only Burroughs Wellcome Co.
gives you

ZYLOPRIM®
(allopurinol)

and a whole lot more!

Full support for you, the physician:

- Continuing medical education materials
- On-going clinical studies
- Physician consultation readily available for your questions concerning Zyloprim
- A choice of 100 mg and 300 mg scored tablets

Full support for your patients:

- Patient starter/conversion kits for easy titration of initial dosage
- Patient education pamphlets to encourage compliance
- Burroughs Wellcome Co. quality and economy

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Prepare For:

- TOEFL
- MSKP
- NATIONAL MEDICAL BDS
- VQE
- ECFMG
- FLEX
- DENTAL BDS
- PODIATRY BDS
- NURSING BDS

- Voluminous home study notes on all areas of basic science.
- Teaching tests accompanied by comprehensive teaching tapes to be used at any of our tape centers.
- Materials constantly updated.
- Over 40 years of experience and success in the field of test preparation.

Stanley H. KAPLAN EDUCATIONAL CENTER

For information Please Call:
Ann Arbor (313) 662-3149
Detroit (313) 569-5320
E. Lansing (517) 332-2539
Centers in More than 115 Major U.S. Cities, Puerto Rico and Toronto, Canada

Diabetes center unit

The Diabetes Center Unit (DCU) of the Michigan Diabetes Research and Training Center in the University of Michigan Hospitals includes an inpatient unit for treatment of patients age 16 years and older with diabetes mellitus. It offers specialized inpatient care, education and training for the patients and their families.

A federal grant has made possible this special program of care and additional physical resources. The DCU program emphasizes techniques of treatment and education so that patients can take increased responsibility for their own care. It is conducted by a team of physicians, nurses, dietitians, and the patient, who is the central member. Each treatment plan takes the individual patient's background and preferences into account.

Difficult therapeutic problems receive special attention; pumped continuous subcutaneous infusion of insulin may be offered to selected patients. Patients who have complicating diseases that are severe may best be hospitalized on the general medical services section of the hospital. The inpatient DCU service is complemented by a DCU outpatient clinic for follow-up care, as needed. A pediatric clinic specializing in the problems of the adolescent with diabetes is also available. Patients are charged usual fees for clinical care.

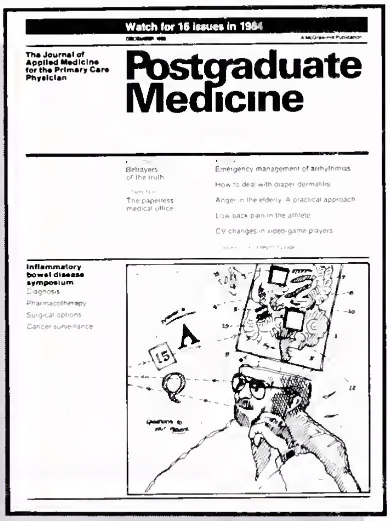
Research costs are met from research funds. Inquiries concerning participation in research studies may be made to John C. Floyd, Jr., MD, Director, Diabetes Center Unit (313) 764-5218.

For admission and outpatient appointment information, please call: Admissions (Adults) (313) 764-6101; Outpatient Appointments (Adults) (313) 763-0283 or (Adolescents) (313) 764-5175.

TURN

TO POSTGRADUATE MEDICINE

Your single, most important source of information on General and Internal Medicine!



Watch for 16 issues in 1984

A McGraw-Hill Publication

The Journal of Applied Medicine for the Primary Care Physician

Postgraduate Medicine

Betrayers of the truth

The paperless medical office

Emergency management of arrhythmias

How to deal with diaper dermatitis

Anger in the elderly. A practical approach

Low back pain in the athlete

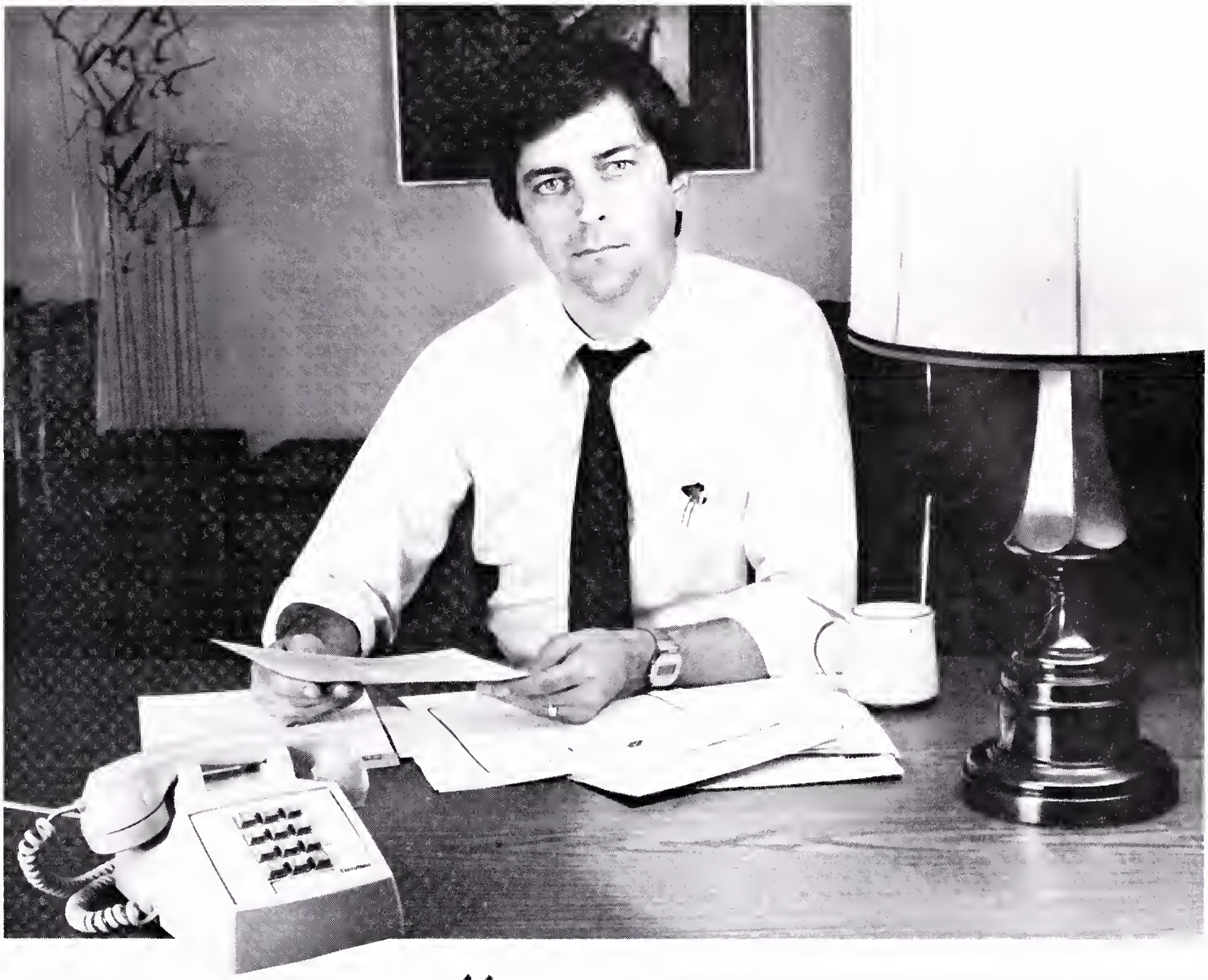
CV changes in video-game players

Inflammatory bowel disease symposium
Diagnosis
Pharmacotherapy
Surgical options
Cancer surveillance

Each issue filled with diverse practical information in all areas of medical practice including:

- IM Subspecialties
- Pediatrics
- Obstetrics/Gynecology
- Emergency Medicine
- Other Key Clinical Areas

Read every issue
Postgraduate Medicine
Where Clinical Diversity is an Art.



"...Your financial security specialist is on call"

American Physicians Life believes a physician's financial security deserves specialized attention. That's why our products and services are designed with the doctor in mind. Our comprehensive portfolio of services, including life insurance, professional disability income coverage, qualified plans and tax-deferred annuities, is customized to meet your personal financial planning needs as well as those of your professional corporation.

Let American Physicians Life secure your financial planning program—that's our specialty!

Call today for the financial security specialist in your area.

AMERICAN PHYSICIANS LIFE
Bates Drive, P.O. Box 281
Pickerington, Ohio 43147
Telephone (614) 864-3900

Toll-free in Ohio, 1-800-282-7515
Toll-free outside Ohio, 1-800-742-1275

By Hira E. Branch, MD

Could the government pay excessive malpractice settlements?

Let us quit fooling ourselves about the lawsuits and malpractice mess.

Why should doctors try to outsmart lawyers at their own game of making laws, interpreting laws and enforcing laws?

Let us make suing patients, their lawyers, the judges, the juries happy. We can, you know. All we have to do is put in practice a solution to this problem, which I will propose later in this communication.

Doctors are swinging at a baseball with a toothpick instead of a bat.

There are two things we know for sure:

1. There are too many lawsuits.
2. There is very little true malpractice. We are paying for maloccurrence.

There has been no solution in the actions of doctors so far:

1. Trying to change laws made by politicians — many of whom are lawyers.
2. Trying to have laws interpreted by judges to help patients and doctors. Many judges are lawyers.
3. Trying to use arbitration, which apparently has been brought to a standstill by trial lawyers and others.
4. Talking about contingency fees for lawyers.
5. Educating doctors to keep proper records and avoid excessive use of tests and x-rays.
6. Establishing malpractice insurance companies that have managed to keep doctors in business. They collect money from doctors to try to satisfy the patients that sue, the lawyers and juries that give out such huge amounts in money judgments. This expense is getting so great that premiums have to be raised and this gradually is forcing doctors out of the private practice of medicine.

Let's face it. We have done very little to help the situation.

Thus, I submit the following proposals:

1. Let's quit fighting the lawyers. They have won almost every battle so far.
2. Let's not put awkward proposals to politicians. The proposals we put might keep them from getting re-elected.
3. Let's propose a hands-off stand so certain patients and their lawyers may sue for little or enormous sums of money.
4. Let's quit criticizing juries who award huge amounts, even millions.

Let's get down to a few basic facts:

1. Doctors no longer can collect enough money to satisfy certain patients, their lawyers and jury awards.
2. Doctors no longer can increase their charges to cover the cost of malpractice insurance rates, and jury awards above the doctors' coverage.
3. Doctors might be able to lower medical costs somewhat and to sleep much better if we could accomplish a proposal such as I am about to make.

Possible Solution

1. Have doctors purchase malpractice coverage up to $50,000 or even $100,000 from a malpractice insurance company.
2. Have the government, state or federal, collect from the people all the money necessary to settle all the judgments above the basic $50,000 or $100,000. This government, state or federal, to disperse all this money to the involved people that the lawyers, judges and juries decide on.

This money could be collected by taxes, by increasing Social Security, by the Dept. of Health or any way that the government, state of federal, decide upon.

This should make the suing public, the lawyers, juries and certain judges happy as there would be no limit to the awards.

The people this money is collected from might not be too happy.

In Summary

I know of no organization, other than the government, that can collect the enormous amounts of money needed to satisfy the present people involved in malpractice cases. *CERTAINLY THE DOCTORS CANNOT.*

Doctor Branch, of Flint, is an orthopedic surgeon.

By Larry J. Sell, MD

Why the Blues want to become a mutual company

Blue Cross and Blue Shield of Michigan (BCBSM) generated a chorus of questions from subscribers, providers of care, employers, hospital administrators, legislators and consumer groups when the company announced earlier this year that it will seek to become a nonprofit, general mutual insurance company.

Physicians, too, asked how the proposed change would effect their relationships with Blue Cross and Blue Shield. The answer: not at all.

That is because BCBSM's proposal to change its corporate structure is not aimed at the various links in health care delivery and financing, but at the company's deteriorating competitive position in the marketplace.

Quite simply, BCBSM believes conversion to a mutual insurance company is necessary if it is to remain competitive and survive. The company sees regulations costing it customers and dollars every year. The company is losing business, and its financial reserves are dangerously low.

The corporation has:

- Suffered underwriting losses of more than $172 million since 1979 on non-group/individual coverages with projected losses through 1985 of $447 million.
- Lost nearly 1,000,000 members over the past 5½ years, costing the corporation $500,000,000 in premium income. As a result, approximately 800 jobs no longer exist. Market share dropped from 58 percent in 1978 to 49 percent at the end of June.
- Experienced a 27 percent drop in reserves in the past four years to 7.8 percent of the previous 12 months of claims and expenses. During the past three years, reserves have fallen nearly $85 million.

In an effort to stop the financial hemorrhaging, the BCBSM board of directors voted to restructure the corporation as a mutual insurance company. That vote was based on the recommendations of a special committee chaired by board member Donald F. Ephlin, a vice president of the United Auto Workers.

The same day the mutualization announcement was made, BCBSM board member William B. Jensen, Jr., MD, Grand Rapids, explained the mutualization proposal to members of the MSMS board of directors and the house of delegates.

Meanwhile, an informal survey by BCBSM board member James J. Humes, MD, found that changing the BCBS plans in Illinois and Florida to mutual insurance plans has had no adverse effects on doctors in those two states.

As a nonprofit mutual, BCBSM would remain a cooperative enterprise in which members would be both the insurers and the insured. Premiums paid by members would create a fund from which liabilities are paid. BCBSM would lose its tax-exempt status as a mutual company.

If proposed legislation is approved, the corporation would no longer be regulated under Public Acts 108 and 109 of 1939.

Let me make it clear that BCBSM is not attempting to escape regulation. As a mutual insurance company, BCBSM would be bound by provisions of the state insurance code, which gives the insurance commissioner the authority to set rates and review practices.

BCBSM could, under mutualization, still enter into reimbursement agreements with physicians to provide them guaranteed and timely payments.

Our intention is to move the present board of directors intact to the restructured mutual corporation, maintaining physician representation. The board would, of course, retain its present authority to change itself if it so desired in the future.

Mutualization won't cause subscriber rates to go up, nor will coverages of high risk lines of business end. Blue Cross and Blue Shield will continue to offer coverage to all segments of the population.

Then why go mutual?

We believe the benefits are many: A strenghtening of our financial foundation; the flexibility to develop, underwrite and market packaged benefit programs for all groups, and combine new products and services in a timely manner, just as our competitors now do; corporation freedom from costly and time-consuming regulation that forces us to be unresponsive to market and customer needs; and, finally, a positive impact on the state through additional jobs as well as taxes to local and state governments.

On the other hand, as Mr. Ephlin's subcommittee report states, if Blue Cross and Blue Shield of Michigan is not allowed to compete on an equal footing and return to solid financial ground, it faces decline and eventual collapse, ending a valuable resource to Michigan.

Doctor Sell is Vice President of Medical Affairs, Blue Cross and Blue Shield of Michigan.

By Busharat Ahmad, MD

We must encourage organ donors

We physicians and surgeons have been doing transplants for a long time. We know the ancient Egyptians and Persians, with their excellent knowledge of medicine, tried tissue transplants in their own primitive way.

Procedures have come of age with recent advances in techniques and the medications to reduce rejection reactions. Interest was sparked by the heart transplants of the last decade, but died down because of our inability to control the rejection process. With new drugs like cyclosporin, there is again interest in transplanting organs like kidneys, livers, and pancreases, as well as hearts and lungs.

The public has become fundamentally aware of all these procedures with recent media interest in seeking livers for transplantation in children. This has brought to the surface some of our basic ethical, moral and social responsibilities as well as the financial burdens and obligation to society. The government has stepped in in a few cases with its own idea of what is right and what is wrong. But with all the interest shown, the primary responsibility still lies with the physician who is the main technician in bringing donors and recipients together.

To coordinate the groups that are doing transplantations, to exchange ideas and knowledge and to set up controls and guidelines, a national organization was formed last month called the American Council on Transplantation. I feel this is a right step toward meeting the needs of the times.

We physicians and surgeons, especially those who are directly involved with the transplant process, understand the needs of people whose lives can be saved or improved by finding a suitable donor. If those of us with direct patient contact can help them decide to leave some of their tissues and organs behind to help others, we will do an exceptional service to humanity. I hope we can not only educate the public into the process of organ and tissue donation, but also help them to make up their minds at the time when it is most appropriate.

There have been tremendous advances in transplantation, but these are all for naught if we cannot find suitable donors in large enough numbers to help those who are unfortunate. We could help 30,000 of our countrymen to see, if we could just improve the donation of corneas by 20 percent. This would be enough to eliminate corneal blindness.

Doctor Ahmad is a Marquette ophthalmologist. He is chairman of the MSMS Committee on Publications and president of the Eye Bank Association of Michigan.

MEDICAL NEWSFRONTS

Zellweger syndrome

A scientist from The University of Michigan Medical School has uncovered an important link in the chain of biological events that leads to a rare lethal disease called Zellweger syndrome. The finding offers hope that the inherited ailment can eventually be prevented or cured.

In a recent edition of the British publication *Nature,* Dutch scientists credit Amiya Hajra, PhD, of U-M with discovering that previously puzzling cell particles called peroxisomes play a key role in the formation of plasmalogens, substances in cell membranes that the Dutch scientists found to be deficient in patients with the syndrome.

Hajra, a U-M professor of biochemistry and researcher in the U-M Mental Health Research Institute, found that peroxisomes in liver, brain and other cells contain enzymes necessary for the production of plasmalogens. Plasmalogens are essential ether lipid components of many cell membranes, including muscle-fiber and nerve cells.

For a decade, researchers have known that infants afflicted by Zellweger syndrome lack peroxisomes, but the cell particles' function remained a mystery until Hajra's discovery. Some researchers had theorized that peroxisomes might be evolutionary descendants of a primitive respiratory system that no longer had a useful role in cellular function.

Professional research

The University of Michigan's School of Public Health and Horace H. Rackham School of Graduate Studies have initiated a program to provide working health professionals with updated research skills without disrupting their employment.

The program is for physicians, dentists, nurses, pharmacists, pharmacologists and psychologists who do research at professional schools, teaching hospitals, research institutes or pharmaceutical companies.

Participants will attend classes only on weekends, using an on job/on campus educational format. Course work will be integrated with the participants' employment so that their work serves as the laboratory for class projects.

In addition to faculty and researchers, the program, which is to begin in early 1985, also is open to individuals with research fellowships.

The program is intended to address two problems in health care — a shortage of faculty trained in research, and inadequacies in the design of medical and dental research.

Persons interested in the program can receive more information from Roy Penchansky, Chairman, OJ/OC M.S. Program in Clinical Research Design and Statistical Analysis, School of Public Health, 109 Observatory St., Ann Arbor 48109-2029.

The AIDS Commitment

AIDS knows its business is serving physicians and their patients, who depend upon our dedication to deliver the best in diagnostic services.

AIDS ensures confidence by providing prompt, accurate and consistent testing services in a wide range of laboratory disciplines.

AIDS strives to conduct all business with integrity, skill and courtesy to each and every client.

AIDS intends to maintain excellence in skills and invest in research and development in order to better serve our clientele in the future.

AIDS understands that good service is the foundation of any business and the best service relies upon having the best people. Our staff of M.D.s, Ph.D.s, highly-skilled technologists and technicians, and AIDS' in-the-field PRO team assures the utmost in dependable, prompt, reliable service.

Allied Integrated Diagnostic Services (AIDS) is Michigan's fastest growing, most progressive full-service clinical laboratory. AIDS comprehensive diagnostic testing comprises a wide range of laboratory disciplines. We are ready to serve your laboratory needs 24 hours a day.

AIDS

ALLIED INTEGRATED DIAGNOSTIC SERVICES
22170 W. NINE MILE ROAD • SOUTHFIELD, MI 48034
313/352-5780
TOLL FREE NUMBER 1-800-AIDS LAB (243-7522)

Your FREE HCN
Coffee Cup!

TAKE A BREAK EACH WEDNESDAY

with **Health Care News**, the most accurate, reliable, and complete way to keep abreast of health care regulations, legislation, mergers, moves, negotiations, people, continuing education, and job opportunities. We give you the news you need to know **52 times a year for only $11. $20 for 2 years & a free coffee cup.**

Health Care News

SERVING MICHIGAN'S HEALTH CARE PROFESSIONALS

Subscribe now. Limited time only.

☐ Payment Enclosed
☐ New
☐ Renewal
☐ Bill me—$1.50 additional
☐ Bill firm—$1.50 additional
☐ Visa ☐ Mastercard

Firm Name (if applicable) ____
Name ____
Address ____
City/State/Zip ____
Interbank # ____ Exp. Date ____
Signature ____
Drivers License Number ____

5440 Cass Avenue • Detroit, Michigan 48202 • (Phone (313) 831-3323
Telephone Orders Accepted

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

1st FOR PROFESSIONAL PROTECTION EXCLUSIVELY

YOUR FIRST STEP TO FIRST QUALITY PROTECTION

CONTACT FIELD REPRESENTATIVES

Eastern Office
JOHN K. GALLOWAY, THOMAS A. WEISMAN, WAYNE M. BACKUS,
MARK A. TISDEL and CHARLES J. ROWE
6785 Telegraph Road, Suite 350, Birmingham, Michigan 48010
(313) 647-6640

Western Office
GEORGE J. HAWORTH
2600 Five Mile Road, NE, Suite 101
Grand Rapids, Michigan 49505
(616) 361-0863

Medical Data Services - Texas Instruments

Working Together To Make Your Practice $UCCESSFUL

MDS, the nation's leading specialist in the business management of **MEDICAL PRACTICES,** has joined with **TEXAS INSTRUMENTS,** the leader in sophisticated computer systems, to provide private physicians with a state-of-the-art, user-friendly, low cost medical billing-accounts receivable management system.

To be more $uccessful **CALL TODAY** for a no-obligation proposal for your practice.

Toll Free in Michigan 1-800-482-6972

TEXAS INSTRUMENTS
COMPUTER SYSTEMS

MEDICAL
DATA
SERVICES

5420 HILL-23 DRIVE
FLINT, MICHIGAN 48507

1-800-482-6972 **313-238-1666**

Medical Data Services is a subsidiary of Charter Medical Corp.

MSMS, MSMS/A, AMA, and medical assistants

May 23 — AMPAC/MDPAC State Political Education Seminar, at MSMS headquarters, contact: Kevin Kelly, MSMS headquarters.

June 17-21 — AMA Annual Meeting of House of Delegates, Chicago, contact: Bruce Ambrose, MSMS headquarters.

July 26-29 — Midsummer Meeting, MSMS Board of Directors, Deer Lake, Boyne Mountain, contact: Warren F. Tryloff, MSMS headquarters.

Sept. 19 — MSMS Board of Directors meeting, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Nov. 13-15 — MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn, contact: Sherry Fent, MSMS headquarters.

Nov. 21 — MSMS Board of Directors meeting, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Dec. 2-5 — Interim meeting of AMA House of Delegates, Honolulu, Hawaii, contact: Bruce Ambrose, MSMS headquarters.

Professional Practice Sales, Inc.
May Have the Perfect Practice For You!

Our guidance and expertise will be at your service whether you are starting out, expanding or ready to sell.

Looking for that ideal location? Consider these available areas:
- Ann Arbor — OB/GYN — Excellent Facility
- Jackson — $500,000 Monthly Income
- Lansing — Family & Industrial Practice
- Bloomfield Hills — Dermatology — Reasonable terms
- Mt. Clemens — Family Practice — 2,000 sq. ft.
- Redford/Plymouth Rd. area — Good location

Professional Practice Sales, Inc.
Caters Exclusively to Health Care Professionals.

27208 Southfield Road
Lathrup Village, MI 48076
(313) 569-7336

Other meetings

May 18-19 — Conservative Treatment of Low Back Pain, Jackson, sponsored by Camp International, Inc., contact: Isabelle S. Green, Medical Informatics Manager, Camp International, Inc., Box 89, Jackson 49204.

May 19 — Michigan Society of Pathologists, business/scientific sessions, Dearborn Inn, Dearborn, contact: Vi Heins, MSMS headquarters, East Lansing.

May 19-26 — Michigan Week, contact: Sharlan Douglas, Greater Michigan Foundation, (313) 963-3396.

May 23 —— Michigan League for Human Services, Legislative Breakfast, Lansing Civic Center, contact: The Michigan League for Human Services, 300 N. Washington Square, Suite 311, Lansing 48933-1293, (517) 487-5436.

May 24 — Laboratory Tests and Arthritis, Harper/Grace Hospitals, contact: Joan Baldwin, Harper/Grace Hospitals, 3990 John R, Detroit, (313) 494-8303.

May 31-June 1-3 — Michigan Association for Medical Education Annual Meeting, Point West, Macatawa, contact: Vi Heins, MSMS headquarters, East Lansing.

June 4-5 — Child Abuse and Neglect: Moving Through the Legal Maze, Towsley Center, University of Michigan Medical School, Ann Arbor, contact: Towsley Center, Box 057, University of Michigan, Ann Arbor 48109, (313) 763-1400.

June 7-9 — American Hospital Association 7th Annual Trustee Forum, Chicago. For program information, contact: B. Olsen, AHA, (312) 280-6301; for registration, contact: Division of Education (312) 280-6083.

June 14-15 — Michigan Chapter, American College of Surgeons Annual Meeting: Day 1, Resident Surgeons Day Competition; Day 2, Scientific Meetings. Grand Traverse Resort, Grand Traverse Village, contact: Viola M. Heins (517) 337-1351.

June 15 — Michigan Society of Thoracic Surgeons, Annual Scientific Meeting, Traverse City, contact: Rodman E. Taber, MD, 1010 Antietam Rd., Detroit 48207.

June 15-17 — Michigan Dermatological Society, Grand Hotel, Mackinac Island, contact: Debbie Sanalis, 1015 Fernwood, Royal Oak, MI (313) 544-1891.

June 23-27 — Michigan Environmental Health Association Annual Educational Conference. The Amway Grand Plaza, Grand Rapids, contact: William E. DeHann, Michigan Environmental Health Association, (616) 774-3089.

June 24-27 — National Environmental Health Association's Annual Educational Conference, Grand Rapids, contact: NEHA, 1200 Lincoln, #704, Denver, CO 80203 (313) 861-9090.

June 29-30 — Michigan Orthopaedic Society, Hidden Valley Resort, Gaylord, contact: John A. Henke, MD, Secretary-Treasurer, MI Orthopaedic Society, 413 Mecosta, Big Rapids 49307.

July 23-25 — 38th Annual Scientific Assembly, Traverse City, sponsored by Michigan Academy of Family Physicians, contact: Dru Love, Executive Secretary, Michigan Academy of Family Physicians, 109 E. Oakland, Lansing 48906.

August 9-12 — Michigan Psychiatric Society Scientific Meeting, Grand Traverse Resort, contact: MPS (313) 552-8666.

August 22-24 — Annual Meeting, Michigan Health Officers Association, Traverse City, contact: Bruce B. Bragg, President, MHOA, PO Box 24143, Lansing 48909.

ELECTIONS '84

In the upcoming 1984 elections Michigan voters will elect a U.S. Senator, 18 Congressmen and 110 State Representatives

MDPAC

MDPAC

MICHIGAN DOCTORS POLITICAL ACTION COMMITTEE

MDPAC *needs* your financial support in order to contribute to the campaigns of candidates responsive to the concerns of the medical profession. It is in the political arena that the major decisions affecting the medical profession are being made. Make a professional membership investment in

MDPAC

An MDPAC investment:

- Reflects physician commitment to political action and results
- Represents a large physician "precinct" motivated to influence the political and legislative processes that affect the practice of medicine
- Provides a coordinated means for medicine to support candidates who recognize and promote the aims of the medical profession

MDPAC Regular Membership	$ 50.00
MDPAC Sustaining Membership	$150.00

(All sustainers receive an MDPAC sustainer pin.)

MDPAC contributions should be written on a personal check

MDPAC, P.O. Box 769, East Lansing, MI 48823

LABORATORY OF CLINICAL MEDICINE

MID-MICHIGAN REFERENCE LABORATORY, II, Inc.
(517) 372-8180

1322 E. Michigan Ave.
Suite 211
Lansing, Michigan 48912

930 E. Mt. Hope Ave.
Lansing, Michigan 48910

2909 E. Grand River Ave.
Suite 104
Lansing, Michigan 48912

W. E. Maldonado, M.D.
Director

Robert B. Foy, Ph.D.
Chief Executive Officer

Ann E. Chernys, M.D.
John W. Dyke, Ph.D.
Dennis E. Freer, Ph.D.
John J. Gillespie, M.D.
Ronald N. Horowitz, M.D.
John R. Kateley, Ph.D.

John J. Lyday, M.D.
Joseph R. Melvin, Ph.D.
Sandra K. Shirley, M.D.
Laurence R. Simson, Jr., M.D.
Susan M. Strate, M.D.
Irene K. Trombley, M.D.

REFERENCE LABORATORY FOR SPECIALIZED PROCEDURES
Specimen Pickup and Delivery of Test Results Daily
House calls are available upon Physician's request
Assignment is accepted from Medicare, Medicaid, Blue Shield and all other insurance carriers.

SSTAF
Staffing Service To American Free-enterprise
Employee Leasing
Instant
Relief
from
Employer
Headaches

Find out how Employee Leasing can create a more lucrative pension plan for you, while lowering your management costs and improving employee benefits and job security. Write for FREE brochure, today!

I want to know more about SSTAF:

NAME ______________________

ADDRESS ______________________

CITY __________ STATE ______ ZIP ______

SSTAF **Mail to:**
Staffing Service To American
Free-enterprise

2095 Niles Road, St. Joseph, MI 49085 (616) 983-1558
Corporate Headquarters: PO Box 1620, Charlotte Amalie, U.S. Virgin Islands 00801

References:
1. Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for retractory angina pectoris. *Am Heart J* 104:672-681, September 1982
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm Experience in 127 patients *N Engl J Med* 302:1269-1273, June 5, 1980

BRIEF SUMMARY
PROCARDIA* (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm In those patients who have had angiography the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e g , where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and or adequate doses of beta blockers

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and or organic nitrates or who cannot tolerate those agents

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities When introducing such concomitant therapy care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs (See Warnings)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers

Severe hypotension and or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina probably related to increased sensitivity to catecholamines Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA

Congestive Heart Failure: Rarely patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA Patients with tight aortic stenosis may be at greater risk for such an event

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested Close observation is especially recommended for patients already taking medications that are known to lower blood pressure (See Warnings)

Peripheral edema: Mild to moderate peripheral edema typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA This edema occurs primarily in the lower extremities and usually responds to diuretic therapy With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction

Drug interactions: Beta-adrenergic blocking agents (See Indications and Warnings) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure severe hypotension or exacerbation of angina

Long-acting nitrates PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination

Digitalis Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers The average increase was 45% Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization

Carcinogenesis mutagenesis, impairment of fertility When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose

Pregnancy Category C Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0 5% Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication Additionally, the following have been reported muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever sweating, chills, and sexual difficulties Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients It remains possible, however, that some or many of these events were drug related Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2% Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0 5% of patients

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase CPK, LOH, SGDT, and SGPT have been noted and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy The relationship to PROCARDIA therapy is uncertain These laboratory abnormalities have rarely been associated with clinical symptoms Cholestasis, possibly due to PROCARDIA therapy has been reported twice in the extensive world literature

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66) 300 (NOC 0069-2600-72), and unit dose (10x10) (NOC 0069-2600-41) The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container

More detailed professional information available on request © 1982, Pfizer Inc

Pfizer **LABORATORIES DIVISION**
PFIZER INC

"I can do things that I couldn't do for 3 yrs. including joining the human race again."

Quotes from an unsolicited letter received by Pfizer from an angina patient.
While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

© 1983, Pfizer Inc.

"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).

for the varied faces of angina

PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

*Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA *brief summary on adjoining page.*

Motrin®
ibuprofen, Upjohn
600 mg Tablets

MOTRIN
600mg

More convenient for your patients.

Upjohn

[illegible] The Upjohn Company

The Upjohn Company • Kalamazoo, Michigan 49001 USA

J-4044 January 1984

AIDS/Continued from page 230

ulceration (herpes), petechiae (thrombocytopenia); pulmonary: cough, dyspnea; gastrointestinal: mouth soreness or dysphagia (Candida), diarrhea; and neurologic: headache, seizure, altered mentation, focal signs (infection or tumor). However, diarrhea in homosexual men is much more often a sign of curable sexually transmitted intestinal infection. Infants with AIDS most often present with failure to thrive; serious bacterial infections are frequent.

Immune function and other laboratory tests

Characteristic of AIDS are defects in cell-mediated immunity (CMI) with normal or high immunoglobulin levels. Two major unresolved issues are (1) how to best test CMI in AIDS; and (2) which immune defects are truly primary. Two abnormalities that are detectable by simple office procedures suggest impaired CMI: persistent lymphopenia and skin test anergy (using controls such as mumps and Candida). It is not clear that any of the more expensive and sophisticated immune tests are superior to these simple tests at present. The most commonly used expensive test is enumeration of T-lymphocyte subsets with calculation of the T-helper: suppressor ratio. This is not a specific test for AIDS. Low ratios, especially with low absolute T-helper cell numbers, are not unique to AIDS. While low ratios are compatible with AIDS, they are also seen in such common conditions as colds, tetanus immunization, prolonged sun tanning and improper blood storage! Thus, this is a test that should be used only by those very familiar with its limitations.

Of interest and concern is the finding that up to 25 to 50 percent of persons at increased risk of AIDS (gays, hemophiliacs and drug abusers) show immune abnormalities. Most of these abnormalities are probably due to factors other than AIDS (see Theories of Cause). However, this abnormal immune state may well enhance susceptibility to AIDS. For this reason, I use immune screening to motivate those who have abnormal results to take the best possible care of their health.

Diagnosing AIDS-related infections and cancers requires a high index of suspicion and very sophisticated biopsy and culture techniques. Many findings can be overlooked if the pathologist or microbiologist is not aware that AIDS is being considered. When lymph node biopsy is performed, the following tests should always be done on the tissue (in addition to routine histopathology): staining for T- and B-cell and T-cell subset markers; and stains and cultures for acid-fast bacilli and fungi. Analysis of the distribution of T-cell subsets within lymph nodes seems promising in helping to distinguish lymph node hyperplasia due to AIDS from that due to the many other possible causes.

Treatment

There is presently no treatment that corrects the underlying immune defects. A number of immunostimulatory drugs have been tried, including interferon, and even bone marrow transplant. Trials have just started with two experimental drugs, interleukin-2 and gamma interferon. Treatment of the AIDS infections and cancers is best done by specialists familiar with AIDS.

Prognosis

The projected mortality of CDC AIDS is 100 percent within three to four years. Median survival after pneumocystis pneumonia is only six to nine months. The most common cause of death is disseminated CMV infection. The prognosis of suspected mild AIDS so far seems much better.

Theories of cause

Based on animal models, the most likely cause of AIDS is a new virus (or viruses). The leading suspects at present are retroviruses. Retroviruses are RNA tumor viruses which make DNA copies of themselves (proviruses) that insert into host chromosomes, thus altering cell function. It was recently announced by the CDC that the cause of AIDS is a human retrovirus called Human T-cell leukemia lymphoma virus, Type III (HTLV-III). A test for the presence of the specific virus may become generally available within six months. The cancers seen in AIDS are probably not due to the AIDS agent itself, since the same cancers are a risk of organ transplantation. Their cause is most likely common viruses that are **opportunistically oncogenic:** Epstein-Barr virus for lymphomas, CMV for Kaposi's sarcoma, and Herpes simplex and the papilloma (venereal wart) virus for squamous carcinomas.

Whatever the cause of AIDS, susceptibility to AIDS is probably influenced by three factors: (1) dose of virus (large or repeated); (2) genetic make-up; and (3) pre-existent immune abnormalities — developmental (neonate), environmental/lifestyle-induced (nutrition, drugs, stress, semen absorption) or viral (preexistent chronic viral hepatitis, repeated CMV exposure, etc.).

Prevention

The only way we can save lives at present is by preventive efforts. For the largest risk group, non-monogamous homosexual men, information is available on safe sexual practices. For comments on the value of immune screening in this group, see Immune Testing. For hemophiliacs, heat-treated factor VIII concentrate and cryoprecipitate may be safer. Patient education materials on AIDS and its prevention are available from Wellness Networks, P.O. Box 1046, Royal Oak 48068. The major precautions for persons with known or suspected AIDS are sexual precautions, not sharing blood-contaminated objects (razors, toothbrush), and not donating blood or organs. An AIDS Support Group is in existence in Detroit for those with AIDS, possible AIDS, AIDS anxieties, and their friends and families (contact Wellness Networks).

The risk of AIDS from transfusion is very low at present (less than one in 100,000) and is less than that of fatal transfusion-related hepatitis. Screening methods for blood donation are all imperfect. At present, voluntary exclusion of increased risk donors seems as good or better than any available blood test. Volunteer blood donations are likely to be as safe as directed donations. Neither directed donation, nor frozen washed red blood cells (theoretically safer, but very expensive) are feasible for general use. Self-donation is possible for some elective surgery.

The hepatitis B vaccine appears perfectly safe and is strongly recommended. Intramuscular immune globulins ("gamma globulin," hepatitis B immune globulin) also appear safe.

Health care workers should be aware that the risk of acquiring AIDS from a patient is extremely low — nil to date. The American Hospital Association considers refusal to care for an AIDS patient as potential grounds for dismissal. Reasonable isolation guidelines should be followed, but excessive ones avoided. Published guidelines also are available for dentists and morticians.

Nevertheless, AIDS continues to engender panic. Physicians must battle both disease and hysteria. A critical factor in this battle is physician attitude and conduct, which serve as examples to others. I hope the example we set will continue to be one that is rational and humanitarian. Such is the tradition of medicine; anything less is unworthy of our profession.

Turn the page for Category I CME quiz.

CME quiz

The MSMS Committee on CME programming, an organization accredited by the MSMS Committee on CME Accreditation, certifies that this activity meets the criteria for one hour Category I credit for the AMA Physician's Recognition Award and toward the relicensure requirements of the Michigan Board of Medicine, provided it is completed as designated.

To obtain one hour of Category I continuing medical education credit, please answer the following questions by circling the correct answer below. Complete and clip this entire page and mail it by Sept. 1 to: Sherry L. Fent, Chief, Section on Physician Education, MSMS, 120 W. Saginaw Street, East Lansing, 48823. Be sure to include a $3 administrative charge.

True or False

1. AIDS is a highly contagious disease. **T F**
2. AIDs is *not* transmitted through the air or by casual social contact. **T F**
3. There is a specific blood test for AIDS. **T F**
4. Weight loss, fatigue, lymphadenopathy and intermittent fever could be signs of mild or early AIDS. **T F**
5. Frequent common bacterial infections are very characteristic of AIDS in adults. **T F**
6. Women can get AIDS through heterosexual relations, drug abuse or transfusion. **T F**
7. To date, no health care workers have acquired AIDS from caring for patients. **T F**

Choose the correct answer. Only one is correct.

8. The present risk of acquiring AIDS from a transfusion is approximately

A. 1 in 10 or greater
B. 1 in 100
C. 1 in 1,000
D. 1 in 10,000
E. 1 in 100,000 or less

9. The incubation period of AIDS may be as long as

A. 1 year
B. 2 years
C. 3 years
D. 4 years

10. The approximate percent of adults who are homosexual or bisexual is

A. less than 1%
B. 2%
C. 5%
D. 10%

I wish to apply for one hour of Category I CME through the MSMS Committee on CME Programming. I have read the article and completed the quiz. I understand that my answer sheet will be graded confidentially, and that notification of my successful completion of the quiz (80 percent of the questions answered correctly) will be sent to me. I also understand that if I do not answer 80 percent of the questions correctly, I will not be eligible for the one-hour Category I credit but may record and/or report the activity in Category V.

Name (please print or type)

Address

City, State, zip code

ME number (above name on *Michigan Medicine* mailing label)

Signature

Evaluation/Comments:

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, (517) 337-1351.

Date: May 14-18, Advances in Internal Medicine. Location: Towsley Center, Ann Arbor. **Sponsor:** Office of CME, U-M Medical School. **Contact:** Office of CME, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 34 hours of Category I Credit.

Date: May 17, Cancer of the Reproductive Systems. Location: Stouffer's, Battle Creek. **Sponsor:** American Cancer Society, Calhoun County Unit. **Contact:** American Cancer Society, Calhoun County Unit, 65 E. Emmett Street, Battle Creek 49017, (616) 962-5129. **Approved for:** 7.5 hours of Category I Credit.

Date: May 17, Perinatal Horizons. Location: Western Michigan University, Kalamazoo. **Sponsor:** Southwestern Michigan Perinatal Association. **Contact:** Marilyn Potgiesser, RN, Educational Services Instructor, Bronson Methodist Hospital, 252 East Lovell Street, Kalamazoo 49007 (616) 383-6405. **Approved for:** 6 hours of Category I Credit.

Date: May 18-19, Conservative Treatment of Low Back Pain. Location: Jackson. **Sponsor:** Camp International, Inc. **Contact:** Isabelle S. Green, Medical Informatics Manager, Box 89, Jackson 49204. **Approved for:** 16 hours of Category I Credit.

Date: May 18-19, 27th Annual Clinic Days: Transfusion and Infusion Therapy in Pediatrics — Current Concepts. Location: Children's Hospital of Michigan, Detroit. **Sponsor:** CME Department, Children's Hospital of Michigan. **Contact:** CME Department, Children's Hospital of Michigan, 3901 Beaubien Blvd., Detroit 48201 (313) 494-5455. **Approved for:** 10 hours of Category I Credit.

Date: May 19-20, Gynecologic Pathology — May 19; Genitourinary Pathology — May 20. Location: Dearborn Inn. **Sponsor:** Michigan Society of Pathologists. **Contact:** Dr. Kenneth McClatchey, Department of Pathology, University of Michigan Hospital, Ann Arbor, 48109. **Approved for:** 3 hours of Category I Credit.

Date: May 21-23, Advances in Pediatrics: Endocrinology, Gastroenterology, Eating Disorders, Non-Invasive Diagnostic Techniques and Pharmacology. Location: Towsley Center. **Sponsor:** Continuing Medical Education, University of Michigan Medical School. **Contact:** Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor, 48109 (313) 763-1400. **Approved for:** 16 hours of Category I Credit.

Date: May 22, Old Brains, New Ideas. Location: Gordon Scott Hall, Detroit Medical Center. **Sponsor:** Wayne State University School of Medicine. **Contact:** H. Goldman, MD, (313) 577-1007 or J. Hazlett, MD, (313) 577-1535. **Approved for:** 5 hours of Category I Credit.

Date: May 22, New Perspectives for Hormonal Treatment of Breast Cancer. Location: 2 Webber Center Conference Room, Harper Hospital, Detroit. **Sponsor:** Wayne State University School of Medicine and Harper-Grace Hospitals. **Contact:** Continuing Medical Education, University Health Center, 4201 St. Antoine Boulevard, Detroit 48201. **Approved for:** 3 hours of Category I Credit.

Date: May 22-24, Real-time Ultrasound in Obstetrics and Gynecology. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Postgraduate Medicine and Health Professions Education, University of Michigan. **Cost:** $575. **Contact:** Office of CME, Department of Postgraduate Medicine and Health Professions Education, The Towsley Center, U-M , Ann Arbor, 48109 (313) 763-1400. **Approved for:** 22.5 hours of Category I Credit.

Date: May 23, Annual Resident Day of the Michigan Branch of A.V.A. Location: Henry Ford Hospital. **Sponsor:** Michigan Branch of A.V.A. **For:** Urology. **Contact:** Riad N. Farah, MD, Secretary Treasurer, Henry Ford Hospital, Department of Urology. **Approved for:** 4 hours of Category I Credit.

Date: June 4-5, Child Abuse and Neglect: Moving Through the Legal Maze. Location: Towsley Center, University of Michigan. **Sponsor:** University of Michigan Medical School. **Cost:** $195 Physicians, $145 Allied Health Care Professionals. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, University of Michigan, Ann Arbor 48109 (313) 763-1400. **Approved for:** 13 hours of Category I Credit.

Date: June 6-8, Current Topics in Blood Banking, 11th Annual Symposium. Location: Towsley Center for Continuing Medical Education. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 12 hours of Category I Credit.

Date: June 7-9, Primary Care Medicine: An Exciting Frontier Revisited. Location: Henry Ford Hospital, Buerki Auditorium. **Sponsor:** Henry Ford Hospital, Continuing Medical Education. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202, (313) 876-3073. **Approved for:** 14.5 hours of Category I Credit.

Date: June 8, Annual Conference of Michigan Occupational Medical Association. Location: Grand Rapids Hilton. **Sponsor:** Michigan Occupational Medical Association and the American Occupational Medical Association. **Contact:** Howard J. Sawyer, MD, Detroit Industrial Clinic, Southfield, (313) 557-3862. **Approved for:** 4 hours of Category I Credit.

Date: June 9, Current Diagnosis of Common Cardiovascular Disorders. Location: St. Clair Inn. **Sponsor:** American Heart Association of Michigan. **For:** Physicians and nurses. **Contact:** Eleanor D. Peterson, RN, American Heart Association of Michigan, P.O. Box 160, Lathrup Village, 48076, (313) 557-9500. **Approved for:** 5 hours of Category I Credit.

Date: June 11-12, Neonatal-Pediatric Intensive Care Seminar. Location: Towsley Center for Continuing Medical Education. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 11.5 hours of Category I Credit.

Date: June 11-15, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsors:** MSU Colleges of Osteopathic Medicine and Human Medicine, and the North American Academy of Manipulative Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

Date: June 13, Update on Geriatrics — 1984. Location: St. John Hospital, Detroit. **Sponsor:** Family Medical Center, Detroit. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road, Detroit 48236, (313) 343-3877. **Approved for:** 7 hours of Category I Credit.

Date: June 15, Michigan Chapter, American College of Surgeons, Scientific Session. Location: Grand Traverse Resort, Traverse City. **Sponsor:** Michigan Chapter, American College of Surgeons. **Contact:** Vi Heins, MSMS headquarters, East Lansing. **Approved for:** 10 hours of Category I Credit.

Date: June 15-16, The Management of Medical Emergencies. Location: Grand Hotel, Mackinac Island. **Sponsor:** MSU College of Osteopathic Medicine. **For:** DOs and MDs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-9714. **Approved for:** 10 hours of Category I Credit.

Date: June 15-16, Traverse City Trauma Symposium, Scientific Session. Location: Grand Traverse Resort. **Sponsor:** Michigan Committee on Trauma, ACS, Michigan Chapter American College of Surgeons, Wayne State University. **Cost:** $35.00. **Contact:** B.E. Henig, MD, Keyport Clinic, PO Box 605, Grayling, 49738, (517) 348-6611. **Approved for:** 4 hours of Category I Credit.

Continued on page 268

Date: June 24-29, 20th Annual Northern Michigan Summer Conference: An Update on Common Clinical Concerns. Location: Hilton Shanty Creek, Bellaire. **Sponsor:** U-M Office of Continuing Medical Education. **Contact:** Office of CME, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 20 hours of Category I Credit.

Date: July 8-10, Bi-annual Meeting, Michigan Academy of Plastic Surgery. Location: Mackinac island. **Sponsor:** Michigan Academy of Plastic Surgery. **Contact:** Joseph Mark, MD, Michigan Academy of Plastic Surgeons, 1900 Wealthy Street, SE, Grand Rapids, 49506. **Approved for:** 6 hours of Category I Credit.

Date: July 19-22, Macula Disease. Location: Mackinac island. **Sponsor:** Michigan Ophthalmological Society. **Contact:** Leslie E. Meissner, MOS Administrator, 302 Eastland Professional Building, Harper Woods, 48225. **Approved for:** 8 hours of Category I Credit.

Date: July 23-25, 38th Annual Scientific Assembly. Location: Traverse City. **Sponsor:** Michigan Academy of Family Physicians. **Contact:** Dru Love, Executive Secretary, Michigan Academy of Family Physicians, 109 E. Oakland, Lansing, 48906. **Approved for:** 15.75 hours of Category I Credit (19-Wyeth Autotutors, 16-ACLS Course).

Date: July 26-27, Coller Penberthy Thirlby Medical Conference. Location: Park Place Hotel, Traverse City. **Sponsor:** Munson Medical Center. **For:** All interested physicians. **Contact:** Norma Powers, Coordinator of Medical Education, Munson Medical Center, 6th and Madison Streets, Traverse City 49684 (616) 922-9544. **Approved for:** 9 hours of Category I Credit.

Date: August 13-17, Tutorial on Direction Action Thrust Manipulative Therapy. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU College of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

Date: September 8, Pediatric Endocrinology. Location: St. John Hospital. **Sponsor:** CME Committee of St. John Hospital. **For:** Interested physicians. **Cost:** $90.00. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road, Detroit 48236 (313) 343-3877. **Approved for:** 8 hours of credit.

Date: September 8-12, Fundamental of Muscle Energy. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU College of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

Date: September 10-12, Hemodynamic Monitoring. Location: Towsley Center, Ann Arbor. **Sponsor:** U-M Dept. of Pathology and Office of Continuing Medical Education. **Contact:** Office of CME, Towsley Center, Box 057, U-M Medical School, Ann Arbor, 48109, (313) 763-1400. **Approved for:** 14.5 hours of Category I Credit.

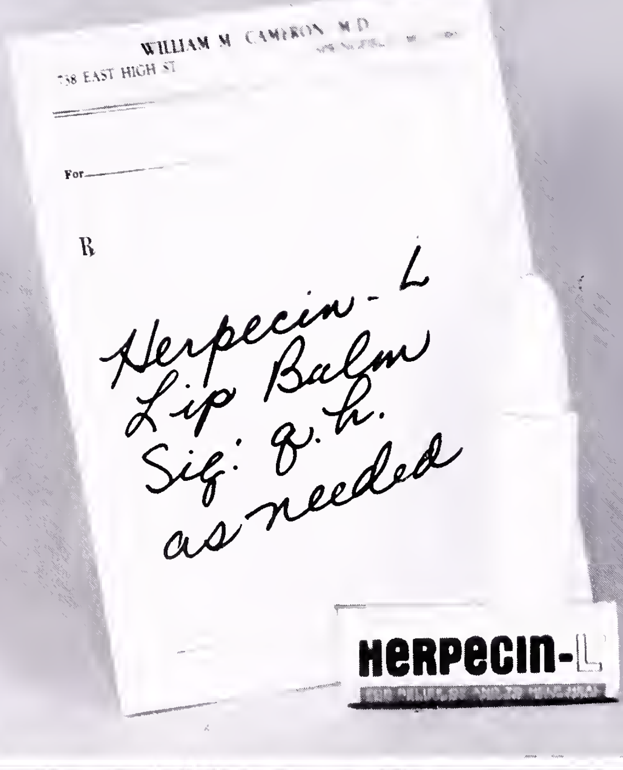
Date: September 21-23, Tutorial on Myofascial Release Technique. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilboum, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 24 hours of Category I Credit.

Date: October 6-10, Advanced Muscle Energy Tutorial (Above Diaphragm). Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilboum, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

Date: October 17, Influencing Unfavorable Pregnancy Outcomes. Location: St. John Hospital. **Sponsor:** CME Committee of St. John Hospital. **For:** Interested physicians. **Costs:** $90.00. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road,Detroit 48236

Continued on page 273

Dx: recurrent herpes labialis



"Herpecin-L Lip Balm is **the treatment of choice** for peri-oral *herpes.*" GP, New York

"In the management of *herpes labialis,* Herpecin-L is a **conservative approach** with **low risk / high benefit.**" Derm., Miami

"Staff and patients find Herpecin-L remarkably **effective.**" Derm., New Orleans

OTC. See *P.D.R.* for information.
For trade packages to make your
own clinical evaluation, write:
CAMPBELL LABORATORIES INC.
P.O. Box 812-M, FDR, NY, NY 10150

In Michigan, "HERPECIN-L" Cold Sore
Lip Balm is available at all *Muir, Perry,*
Revco and *Sentry* Drug Stores and
other select pharmacies.

Who needs over a million dollars in professional liability protection?

Very Possibly YOU Do!

The Michigan lawyers' MILLION DOLLAR CLUB is comprised of attorneys who have won awards over that amount, many from physicians or surgeons who had exercised their very best judgement.

And the jury awards continue to grow.

The Michigan Doctor's Excess Professional Liability Insurance affords...

Protection That Starts When Your Present Policy Stops — And The Jury Keeps Going.

It does not replace your present policy, but it surely supplements it — up to $3 million additional limits.

Now Is The Time To Act!

Changes are effective right now that could be very beneficial to you and your practice. Such as:

— The availability of limits of liability up to **$3,000,000/$3,000,000** excess of $200,000/$600,000 or excess of $1,000,000/$1,000,000;

— A **rate reduction of 10%** for all classes purchasing limits in excess of $200,000/$600,000;

— For P.C.'s, clinics, etc., **discounts up to 50%** for relief or substitute physicians;

— **40-30-30 payment plan** available for annual premiums of $5,000 and above.

For further details about Michigan Doctor's Excess Professional Liability Insurance, please contact HASCO or your insurance agent.

Underwritten by: **PACIFIC EMPLOYERS INSURANCE COMPANY**
Los Angeles, California

Serviced by:
HASCO
P.O. Box 33008
Detroit, Michigan 48232
(313) 567-1955

Gilbert M. Berman, MD
Huntington Woods
Gilbert M. Berman, MD, died on March 8. He was 55. Doctor Berman practiced in the Woodland Clinics in Detroit and Novi. He was a graduate of the Northwestern University Medical School in 1954. Doctor Berman was a 1962 Fulbright scholar in cardiology and a fellow of the American College of Cardiology.

Thomas D. Campbell, MD
Traverse City
Thomas D. Campbell, MD, Traverse City, died on February 13. He was 63. Doctor Campbell was a graduate of Tulane University School of Medicine and served his internship at Mercy Hospital of New Orleans. He was a member of the American Psychiatric Association and served in the military from 1939 to 1945.

Joseph K. Heckert, MD
East Lansing
Joseph K. Heckert, MD, East Lansing, died on March 18 at the age of 87. Doctor Heckert practiced in the Lansing area for the last 50 years. He received his medical degree from the University of Michigan Medical School and did his post graduate work in Vienna and Budapest. Doctor Heckert was a World War I veteran and an active member of the Lansing Elks Lodge.

Wilfred S. Nolting, MD
Bellaire
Wilfred S. Nolting, MD, Bellaire, died on March 5 at the age of 76. Doctor Nolting practiced medicine in the Detroit area for 41 years before retiring in 1978. He was a lieutenant commander in the Navy Medical Corps during World War II and was stationed in the South Pacific. Doctor Nolting was past president of the Detroit Pediatric Society and a member of numerous medical associations. He received his medical degree from the University of Michigan Medical School.

Wesley G. Reid, MD
Plymouth
Wesley G. Reid, MD, Plymouth, died on February 28. He was 80. Doctor Reid was a graduate of the University of Michigan Medical School. He was the former commanding officer of the Seventh Station Hospital in the U.S. Army. Doctor Reid served in the invasion of North Africa and Italy during World War II. After the war he stayed in the Reserves, where he reached the rank of colonel.

Frederick C. Ryan, MD
Kalamazoo
Frederick C. Ryan, MD, Kalamazoo, died on March 28 at the age of 73. He graduated from the University of Michigan Medical School. Doctor Ryan was affiliated with Borgess and Bronson Hospitals in Kalamazoo. He served in the United States Navy from 1942 to 1946.

Albert D. Ruedemann, MD
Grosse Pointe
Albert D. Ruedemann, MD, Grosse Pointe, died on March 13 at the age of 58. He was a graduate of the University of Michigan Medical School. Doctor Ruedemann did pioneering work in electroretinography and was director of the electroretinography lab at Kresge Eye Institute. He was also a clinical associate professor in the ophthalmology department at Wayne State University Medical School. Doctor Ruedemann was a flight surgeon in the Air Force from 1952 to 1954.

C. Alan Tressler, MD
Big Rapids
C. Alan Tressler, MD, Big Rapids, died on March 4 at the age of 47. He received his medical degree from the University of Michigan Medical School. Doctor Tressler served with the United States Navy before he entered a residency in radiology at Harper Hospital in Detroit. He practiced in Rochester and then was at Burns Clinic in Petoskey. He moved to Big Rapids in 1982.

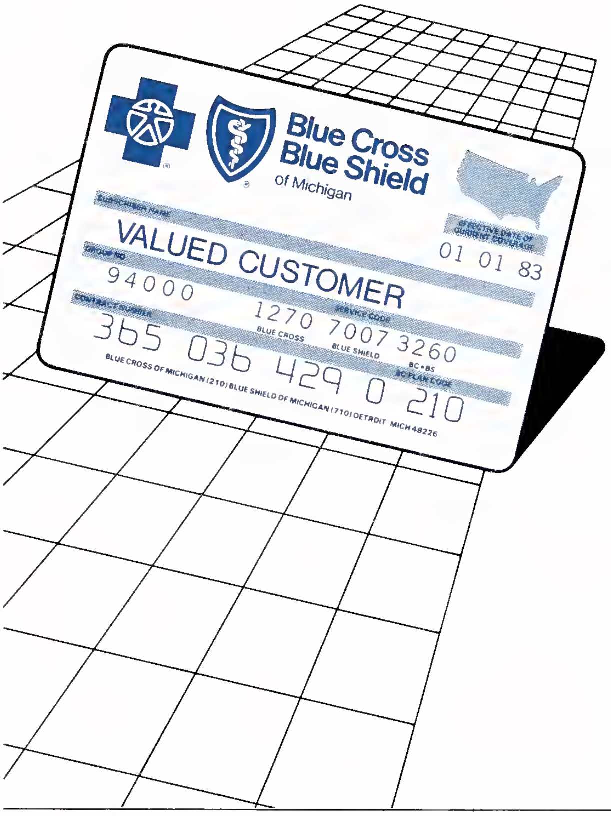
Paul K. Truba, MD
Grosse Pointe
Paul K. Truba, MD, Grosse Pointe, died on January 25 at the age of 69. He was a graduate of Wayne State University School of Medicine and was affiliated with Detroit Memorial and Receiving Hospitals. Doctor Truba served with the United States Navy from 1943 to 1946.

Jack V. Turnbull, MD
Dearborn Heights
Jack V. Turnbull, MD, died on March 12. He was 70. Doctor Turnbull was a graduate of the University of Michigan Medical School. He was a pediatrician in the Dearborn area for 43 years. Doctor Turnbull was on the staff at Providence Hospital in Southfield and at Mt. Carmel Mercy, Sinai and Children's hospitals in Detroit. He retired in 1983.

D. Bruce Wiley, MD
Mt. Clemens
Former MSMS Council (Board of Directors) Chairman D. Bruce Wiley, MD, Mt. Clemens, died on March 24. He was 79. Doctor Wiley was a graduate of the University of Western Ontario Medical School and interned at St. Joseph Hospital, specializing in obstetrics and gynecology. He practiced in Utica from 1929 until his retirement in 1966, when he moved to Lansing. He served then as hospital consultant to the Bureau of Medical Care Administration in the Michigan Department of Public Health. Doctor Wiley served four years as chairman of the Council of MSMS and served seven years as MSMS secretary. He also was a Macomb County delegate to the MSMS House of Delegates for 10 years.

DIMENSION III

LOW-COST HEALTH CARE COVERAGE FROM BLUE CROSS AND BLUE SHIELD OF MICHIGAN.


Blue Cross
Blue Shield
of Michigan
SUBSCRIBER NAME
VALUED CUSTOMER
EFFECTIVE DATE OF CURRENT COVERAGE
01 01 83
GROUP NO
94000
SERVICE CODE
1270 7007 3260
BLUE CROSS
BLUE SHIELD
BC•BS
CONTRACT NUMBER
365 036 429 0 210
BC PLAN CODE
BLUE CROSS OF MICHIGAN (210) BLUE SHIELD OF MICHIGAN (710) DETROIT MICH 48226

Now there's a new low-cost health care plan for Michigan State Medical Society members and their employees. It's Dimension III from Blue Cross and Blue Shield of Michigan . . . a health care plan in which the subscriber shares in the cost of the covered services. Dimension III is a lower cost alternative to the other health care plans presently available to doctors and their employees. Here's how the plan works.

Dimension III for doctors:
Deductible — $ 500 one person
$1,000 family

Dimension III for employees:
Deductible — $100 one person
$200 family

Once the deductible amount has been met, Dimension III pays 80% and the subscriber pays a 20% copayment for covered health care services. When the subscriber has paid $1,000 in copayments, no further copayments are required. Dimension III pays 100% up to $1 million. And when you select one of these plans, you'll get all the benefits that characterize the best health care coverage available:

- ☐ Hospital care benefits.
- ☐ Surgery.
- ☐ Maternity care.
- ☐ Outpatient care benefits.
- ☐ Psychiatric care benefits.
- ☐ The I.D. card that's recognized everywhere.
- ☐ A minimum amount of paperwork.
- ☐ A statewide network of Blue Cross and Blue Shield Service Centers to assist you and your employees.
- ☐ Worldwide coverage for you and your family.

Blue Cross and Blue Shield coverage is the choice of over 5 million Michigan residents. Why not make it your choice, too?
For enrollment information, call your local Blue Cross and Blue Shield of Michigan representative.

CAN YOU REALLY AFFORD ANYTHING LESS?

Blue Cross
Blue Shield
of Michigan

The rate for each classified advertisement in *Michigan Medicine* is 20¢ per word, with a minimum charge of $10.00. Copy for classified advertisements should be received no later than the first of the month preceding the month of publication.

Positions Open

EMERGENCY DEPARTMENT MEDICAL DIRECTOR: Low volume hospital based emergency department in suburban Detroit, competitive salary and excellent benefits. Send letter of interest with CV to Michael C. Tomlanovich, MD, Department of Emergency Medicine, Henry Ford Hospital, 2779 W. Grand Blvd., Detroit 48202.

OPERATING CORPORATION OF SEVERAL MEDICAL CENTERS providing primary care for senior citizens seeks Board Certified or Board Eligible, Florida licensed MDs with the following specialties . . . Family Practice, Internist, Cardiologist and Radiologist. Salary plus incentive. Insurances paid. Association fees paid. Contact Mr. Ed Hoke, H.S.C. Medical Centers, 1529 US 19 South, Levitz Center, Clearwater, FL 33546. Phone (813) 530-9455.

MEDICAL RESIDENT IN PSYCHIATRY WANTED for diagnosis, treatment and patient care in all areas of psychiatry under supervision of hospital staff. Requires MD degree and one year related experience as a physician. 40 hours per week; $19,000.00 per year. Send resumés to 7310 Woodward Avenue, Room 413, Detroit 48202. Ref.No. 3284.

GASTROENTEROLOGIST — NEUROLOGIST — NEUROSURGEON: Independent group of private practitioners searching for an independent-practice oriented BC/BE gastroenterologist, neurologist, and neurosurgeon. Referral base includes 100 physicians, serving a population of 120,000. Unlimited recreational activities, medium sized university city. Immediate need. Chippewa Valley Independent Physicians, P.O. Box 1725, Eau Claire, Wisconsin 54702.

PEDIATRICIAN: SHARE BUSY practice with Multispecialty Group in Midwestern town of 10,000. Many fringe benefits with newer facilities and 175 bed hospital. Outdoor fun unlimited. Call or write Lawrence O. Garber, MD, 520 Cobb Street, Cadillac 49601 (616) 775-6521.

FAMILY PRACTITIONERS, GENERAL PRACTITIONERS or Emergency Medicine Physicians — with practice experience wanted for free-standing urgent care centers located in the Central Michigan area. Excellent access to recreational areas. Associate Medical Director opening immediately. Medical Director opening in July or August of 1984. Salary negotiable plus fringe benefits. Send CV to Contemporary Medical Management, Inc., 401 S. Euclid Avenue, Bay City 48706 (517) 667-0494.

ORTHOPEDIC SURGEON: Two busy, family oriented, orthopedic surgeons seeking third. Must be Board Certified or eligible and have hand surgery experience. Practice covers large geographic area involving two hospitals and two offices in northern lower Michigan. Please respond in writing to: N'Orthopedics PC, P.O. Box 340, Gaylord 49735.

FAMILY PRACTICE (BATTLE CREEK) — Two man family practice seeking one or two physicians doing over $400,000 gross yearly. Serving area of 100,000 with three open hospitals. Salary first year. Full partner after one year. Health insurance, disability insurance, pension and profit sharing plans, six weeks vacation. Inquire to Cinde VanDusen, Capital Avenue Medical, PC, 719 Capital Avenue SW, Battle Creek, 49015. Phone (616) 965-5188 (9am-5pm).

WANTED: Board certified or eligible Ophthalmologist to join general ophthalmology practice in Michigan's Upper Peninsula. Reply with Curriculum Vitae to: G. Richard Keskey, MD, Mid Peninsula Eye Clinic, 2600 College Avenue, Escanaba, 48929.

ORTHOPAEDIST — for Occupational Medicine Department at Henry Ford Hospital-Fairlane Center, to do musculoskeletal disability evaluations and some minor treatment; no surgery; part-time position, minimum of 12 hours per week; must have knowledge of and experience with disability evaluation process; prior activity in occupational medicine not required; send curriculum vitae to: Michael E. Somand, MD, Medical Director, Henry Ford Hospital-Fairlane Center, 19401 Hubbard Drive, Dearborn, 48126.

GENERAL SURGEON — Active two man surgical practice located near two large urban areas is looking for an allopathic or osteopathic trained, Board Eligible or Board Certified general surgeon. Please send curriculum vitae to Surgical Specialists, P.C., 544 North Main, Lapeer, 48446, (313) 664-4100.

ONCOLOGIST — Mid-Michigan community seeks oncologist for service area of 70,000. Guaranteed first year income of $120,000. Office space available in medical office building adjacent to the hospital. 236 bed hospital provides major diagnostic capabilities. Excellent opportunity for a physician seeking a very busy private practice opportunity with guaranteed financial success. Submit C.V. to Box 55, Michigan Medicine, 120 W. Saginaw, East Lansing, 48823.

GASTROENTEROLOGIST — Mid-Michigan community seeks gastroenterologist for service area of 70,000. Guaranteed first year income of $120,000. 236 bed hospital provides excellent diagnostic capabilities. Office space available in medical office building adjacent to hospital. Excellent opportunity for a physician seeking a very busy private practice opportunity with guaranteed financial success. Submit C.V. to Box 55, Michigan Medicine, 120 W. Saginaw, East Lansing, 48823.

MICHIGAN: EMERGENCY CONSULTANTS, INC. currently staffs Emergency Departments throughout the state. Full-time and part-time positions available in rural and urban locations. Guaranteed hourly rate plus malpractice insurance. Contact Emergency Consultants, Inc., 2240 South Airport Road, Suite 115, Traverse City, 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

THE GRAND RAPIDS DIVISION OF THE DETROIT INDUSTRIAL CLINIC is in need of an additional physician. Preference is for a physician with approximately 5 years practice experience and a background of family practice, surgery, internal medicine, ER, orthopedics or psychiatry. Send CV to R. R. Silver, MD, Detroit Industrial Clinic, 20755 Greenfield Road, Southfield, 48075.

POSITIONS WITH THE STATE OF MICHIGAN — Currently taking applications for positions expected to be available in the future. Office locations now include Kalamazoo, Lansing, Southfield, and Traverse City. A board certified or board eligible psychiatrist needed for the Kalamazoo office, and internists with rheumatology or cardiology background desired for other offices. Beginning salary in low 60s with approximately 26% fringe benefits. An equal opportunity employer. All inquiries treated confidentially. For further details, please write: Harry D. Nesmith, MD, Chief Medical Consultant, Disability Determination Service, PO Box 30011, Lansing, 48909.

GENERAL INTERNISTS AND FAMILY PRACTITIONERS interested in geriatric medicine will find an optimal practice setting in our Sun City, AZ healthcare centers. CIGNA Healthplan, Inc., one of the nation's largest prepaid health plans, offers an opportunity to practice medicine free of the business aspects. Night and weekend call is very light. Competitive salaries. Excellent benefits. Please respond to: Director, Professional Recruitment, PO Box 29030, Phoenix, AZ 85038 (602) 954-3506.

FAMILY PHYSICIAN: IMMEDIATE OPENING for a residency trained FP preferring small-town life style and interested in "whole person medicine from the Christian perspective" in a new office in the small college town of Hillsdale in southern Michigan. Write or call: Frederick L. Bean, MD, Hillsdale Family Practice, 111 South Howell, Hillsdale, 49242, (517) 437-7307.

Positions Wanted

MD FULLY LICENSED WITH 2 YEARS of residency training, pursuing doctorate studies, starting July 1, 1984; desire part-time — evenings or weekend employment within drivable distance from Ann Arbor. Emergency room experience. ACLS certified. Excellent references. Box 57, Michigan Medicine, 120 W. Saginaw, East Lansing 48823.

Miscellaneous

HOWELL, MI — Two suites available in attractively designed medical-dental building. Complex conveniently located within walking distance of hospital which serves fastest growing county in the state. Unlimited opportunity for hardworking family practitioner looking to establish large practice. For information, call (517) 546-7630.

LEASE — ADA, MI MEDICAL SUITE. A doctor is needed in this area. Ada is one of the most desirable and fastest growing residential sections in the Grand Rapids area. Like new, with 1,600 square feet, this 10 room suite is perfect for one or two doctors. It can be leased for $1,300 on a carefree basis. Ownership possible. Also available are two medical buildings on northwest side under $150,000. Call Charles Gibson, (616) 942-7747 or The Real Estate Office (616) 458-1595.

MEDICAL OFFICE SPACE AVAILABLE the end of 1984. 2600 sq. feet of office space with shared waiting room. Linden Bristol Square, 5119 W. Bristol Road, Flint 48504. (313) 732-1620.

BIG TWIN LAKE, KALKASKA COUNTY — Custom ranch, 2000 sq. ft. luxury living. Features include wet bar, recreation room, fireplace, cedar walk-in closets, 3 bedrooms, 2½ baths, large deck area, 100 ft. sugar sand beach and much more. For sale by owner. Priced at $125,000.00. Phone (616) 587-8238.

SAILORS OR GOLFERS — Great opportunity on Southern Lake Michigan. Free standing walk-in facility. New complex. Prefer ER experience. $62,000 minimum. Potential opportunity to invest. Average 42 hours per week. Call (616) 429-1760 or 429-9714.

EQUIPMENT WANTED: Am Furnishing 3 new examination rooms and need used equipment in good condition. Am interested in 2 clinical examination tables of the standard type for gynecologic examinations, 1 power Ritter table for proctoscopy and procedures. 3 hydrolic type physician's stools, and 3 treatment cabinets. Contact J. Phillips, MD, 802 E. Chicago Road, Sturgis 49091, (616) 651-4426.

USED LABORATORY EQUIPMENT like new, Chemtek, Celltract^5, Riaphase, and Centifuge (Clay-Adams). Call weekdays 9AM-7PM, (313) 557-3303.

MEDICAL/PROFESSIONAL BUILDINGS FOR SALE OR LEASE! Two buildings available in Prime Grand Rapids Locations. Approximately 2,000-3,000 sq. ft. Owner will lease all or part or will sell on 11% land contract. Doctor-owner will sacrifice to doctor starting practice or to established doctor wishing to purchase or expand to new facilities. MAKE OFFER! Call Mike Anderson at Liberty Realty (616) 455-7179.

HYANNIS, CAPE CODE & NEWPORT, RI: Condo Rentals. Executive townhouses on beach. 3 bedroom, 3 bath, pool, tennis. Private decks. Country seclusion near city activities. $1,250 week summer. Off-season before June 16, after September 1. ST. THOMAS BEACHFRONT CONDO: 2 bedroom, 2 bath, $1,400 week season, $735 week off-season. (617) 678-2500.

FOR SALE: General practice in lower thumb area. Attractively priced with generous terms available. Contact: Michigan Practice Brokerage Corporation (313) 827-8874.

IDEAL LOCATION heavy traffic — Strip Shopping Center. $600 per month — Walled Lake, share space with Podiatrist. Dr. S. Cyril Leib, DPM, 1266 S. Commerce Road, Walled Lake, 48088.

FOR LEASE — IN OAKLAND COUNTY in the beautiful lakes area of Union Lake and Walled Lake. Area is growing but with a solid base of older homes. New professional buildings in what will be "the" place to go for health and dental care. A place with an "identity." Custom designed suites from 1,200 to 6,000 s.f. Ideal for specialists as they are needed in this area. A great area to live in! For more information call (313) 363-3228 or 625-0660.

Rx PADS PRINTED to your specifications. $20.00 per thousand in pads of 100. $21.00 one time set up charge. Shipping additional. Small Craft Printing Company, 211 E. Kalamazoo St., Lansing, 48933 (517) 485-0553.

PREVIOUSLY OWNED MEDICAL LABORATORY AND OFFICE EQUIPMENT available in excellent condition. We buy, sell, trade, move and repair. Office assessments available by certified surgical consultants. Call Doctor Medical Resale, Ltd. (313) 569-4407, 9 AM to 9 PM.

SAIL BEAUTIFUL LITTLE TRAVERSE BAY — Lake Michigan Hagerman's Sailing School, Petoskey, MI. Two, three or five day courses of instruction for novices or new cruising sailors aboard a 27′ sloop $60 per person/per day. Skippered charters! Reserve preferred dates early. Write or call: 1630 Milrose, East Lansing, 48823 (517) 337-7009.

1984 CME CRUISE/CONFERENCES ON LEGAL-MEDICAL ISSUES — Caribbean, Mexican, Hawaiian, Alaskan, Mediterranean. 7-14 days in Winter, Spring, Summer. Approved for 18-24 CME Cat. 1 credits (AMA/PRA). Distinguished professors. FLY ROUNDTRIP FREE ON CARIBBEAN, MEXICAN & ALASKAN CRUISES. Excellent group fares on finest ships. Registration limited. Pre-scheduled in compliance with present IRS requirements. Information: International Conferences, 189 Lodge Ave., Huntington Station, N.Y. 11746. (516) 549-0869.

DOCTOR, YOU CAN'T BEAT THE QUALITY OR THE PRICE! Holter Monitor scanning service. Physician owned, trained and supervised. $35.00 for cassette reports; $45.00 for reel to reel reports; no contracts to sign. We can arrange for lease/purchase of Holter equipment. Why are you paying more and getting less? DCG Interpretation (313) 879-8860.

ATTENTION DOCTORS: We have previously owned medical, laboratory, office and x-ray equipment in excellent condition. We buy, sell, trade, move and repair. Office appraisals available by certified surgical consultants. Call Doctor Medical Resale at 313-569-4407, 9 am-9 pm.

PHYSICIANS SIGNATURE LOANS TO $50,000. Up to 7 years to repay. No repayment penalties. Prompt, courteous service. Competitive fixed rate, with no points, fees or charges of any kind. Physicians Service Association, Atlanta, GA. Toll-free (800) 241-6905.

CATEGORY I/Continued

(313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: October 25-27, 15th Annual International Symposium on Implant Surgery for the Hand and Upper Extremity. Location: Blodgett Memorial Medical Center and Amway Grand Plaza Hotel, Grand Rapids. **Sponsor:** American Society for Surgery of the Hand. **Contact:** Alfred B. Swanson, MD, 290 Blodgett Professional Building, 1900 Wealthy Street, SE, Grand Rapids, 49506 (616) 774-7394. **Approved for:** 19 hours of Category I Credit.

Date: October 26-28, Manual Medicine Principles Applied to the Extremities. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 24 hours of Category I Credit.

Date: October 27, Annual Meeting of Michigan Neurological Association. Location: Botsford Inn, Farmington. **Contact:** Raymond B. Bauer, MD, 4201 St. Antoine 6G, Detroit 48201 (313) 494-4281. **Approved for:** 4 hours of Category I Credit.

Date: November 13, 14 & 15, Annual Scientific Meeting. Location: Hyatt Regency Dearborn. **Sponsor:** Michigan State Medical Society. **For:** All interested physicians. **Contact:** MSMS headquarters (517) 337-1351. **Approved for:** Maximum of 18 hours of Category I Credit.

Date: November 14, Alcoholism. Location: St. John Hospital. **Sponsor:** CME Committee of St. John Hospital. **For:** Interested physicians. **Cost:** $90.00. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road, Detroit 48236 (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: December 3-7, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine, and North American Academy of Manipulative Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

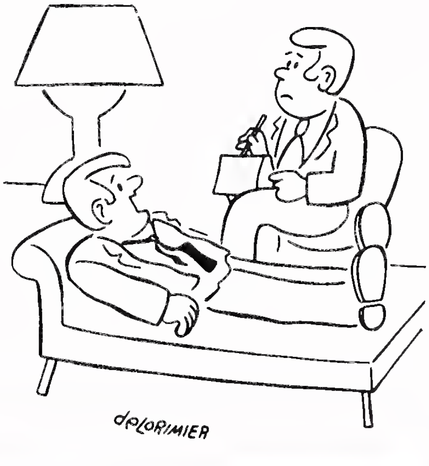
Date: February 27, 1985, Cardiology-Update. Location: St. John Hospital. Sponsor: CME Committee of St. John Hospital. **For:** Interested physicians. **Cost:** $90.00. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road, Detroit 48236, (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: May 8, 1985. Pancreatitis. Location: St. John Hospital. Sponsor: CME Committee of St. John Hospital. **For:** Interested physicians. **Cost:** $90.00. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road, Detroit 48236, (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: June 12, 1985. 1985 Geriatrics-Family Practice-Update. Location: St. John Hospital. Sponsor: CME Committee of St. John Hospital. **For:** Interested physicians. **Cost:** $90.00. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road, Detroit 48236, (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Thanks to our advertisers

AIDS	257
AMRC	245
American Physicians Life Insurance Co.	253
Blue Cross/Blue Shield	271
Birmingham Motors, Ltd.	239
Brown Pharmaceutical Co.	237
Burroughs Wellcome	251
Campbell Laboratories	268
HASCO	269
Health Care News	258
Stanley H. Kaplan	252
Lab of Clinical Medicine	261
Life of Virginia	246-47
Eli Lilly & Co.	235
MDPAC	261
MPMLC	232-33
Medical Data Service	259
Medical Protective Co.	258
PICOM	243
Pfizer Lab	262-63
Postgraduate Medicine	252
Professional Practices Sales	260
Roche Laboratories	IBC-BC
STAFF	262
Stratton-Cheeseman	IFC
Union Bank & Trust Co.	238
Upjohn Company	264



"I'm E.F. Hutton, and nobody listens!"

Will economics turn us from our public trust?

At a time when the economics of health care dominates public attention and discussion to an unparalleled degree, it may be profitable for us physicians to individually and collectively reflect upon our primary responsibility.

Although one cannot deny the importance of economic considerations in providing medical care to our patients, these considerations should not, and must not, be paramount. Physicians have traditionally over the ages cared for those entrusted to us without regard to their financial status.

I do not believe that the advent of DRGs, PPOs, HMOs, and preadmission certification should significantly change our professional values or our dedication to our patients. The frightened, elderly widow in an emergency room with a hip fracture or the middle-aged man in the CCU with an acute mycardial infarction doubtless have not heard of the myriad of innovative alternative health care delivery plans or reimbursement mechanisms and couldn't care less. Both, however, appreciate and deserve a competent and caring physician without regard to the views of health planners, politicians, third party payors, or any of the other actors on the health care scene.

I am not for one minute suggesting that our 10 to 12 percent of the gross national health care product is unimportant. Nor am I suggesting that inappropriate or unnecessary medical care is to be condoned.

Louis R. Zako, MD
MSMS President

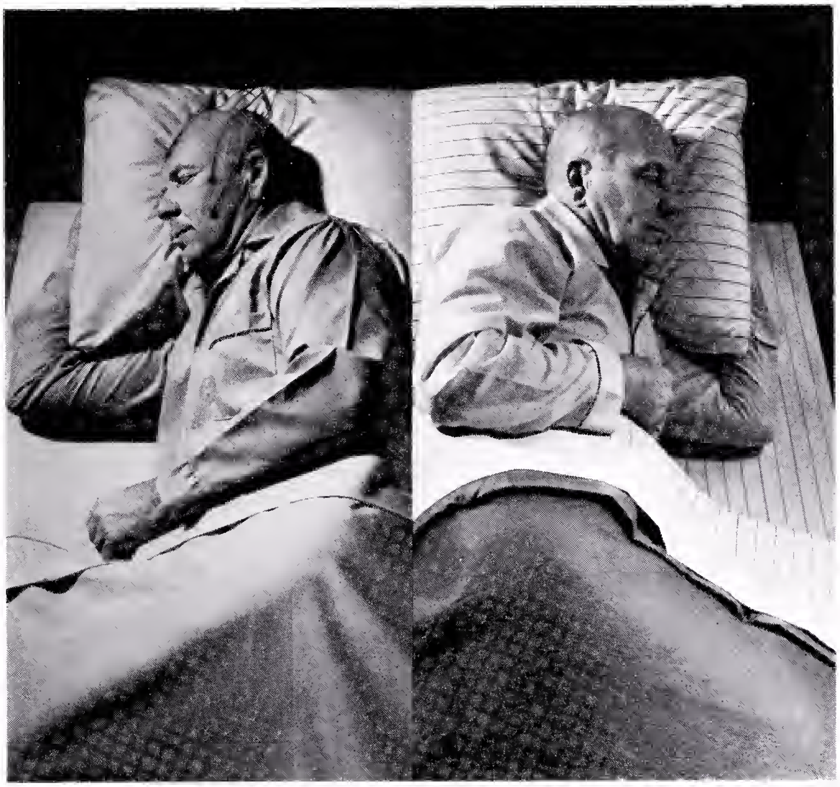
I am instead suggesting that we physicians have an almost sacred trust, that we must re-dedicate ourselves to this trust, and that we must not betray that trust, regardless of the external pressures brought to bear.

Harry Schwartz, in a recent article in the Wall Street Journal, asks the question: "Can economics be the bottom line for medicine?" Professors Henry J. Aaron and William B. Schwartz write in their recently published book *The Painful Prescription: Rationing Hospital Care,* that "(British) physicians, for example, have had to learn to say no in ways that are acceptable both to themselves and to their patients." In a chapter entitled "Matters of Life and Death," they describe how so many fewer cases of kidney failure are being treated in Britain than in the United States and other countries. The authors point out that resource constraints, rather than medical criteria, are largely responsible for the lower rate of dialysis in Britain, and that age is the chief factor in refusing treatment (rarely is a person 55 years of age or older dialyzed).

After having interviewed dozens of British physicians in preparation for their book, Professors Aaron and Schwartz write, "It is easy, moreover, to imagine that conscientious doctors, confronted with the continual frustration of having to turn patients away, might fashion criteria that justified a refusal to treat. Sometimes, however, such rationalizations fail, and the doctor faces a real dilemma."

If and when we in the United States reach the point of medical resource allocation achieved many years ago in Great Britain, how will we physicians respond? Will we, as have many of our British colleagues, rationalize our denial of a total hip replacement for a 55-year-old or for that matter, a 75-year-old, otherwise healthy patient? Or will we keep the public trust?

COMPLETE LABORATORY DOCUMENTATION[1-5]... EXTENSIVE CLINICAL PROOF



FOR THE PREDICTABILITY CONFIRMED BY EXPERIENCE

DALMANE® (IV)
flurazepam HCl/Roche

THE COMPLETE HYPNOTIC PROVIDES ALL THESE BENEFITS:

- Rapid sleep onset[1-6]
- More total sleep time[1-6]
- Undiminished efficacy for at least 28 consecutive nights[2-4]
- Patients usually awake rested and refreshed[7-9]
- Avoids causing early awakenings or rebound insomnia after discontinuation of therapy[2,5,10-12]

Caution patients about driving, operating hazardous machinery or drinking alcohol during therapy. Limit dose to 15 mg in elderly or debilitated patients. Contraindicated during pregnancy.

DALMANE® (IV)
flurazepam HCl/Roche

References: **1.** Kales J *et al*: *Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A *et al*: *Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A *et al*: *Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A *et al*: *Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol 3*:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **9.** Amrein R *et al*: *Drugs Exp Clin Res 9*(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol 3*:303-326, May 1981. **11.** Greenblatt DJ *et al*: *Sleep 5*(Suppl 1):S18-S27, 1982. **12.** Kales A *et al*: *Pharmacology 26*:121-137, 1983.

DALMANE® (IV)
flurazepam HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

DOCUMENTED IN THE SLEEP LABORATORY[1-5]...

PROVEN IN THE PATIENT'S HOME

FOR A COMPLETE NIGHT'S SLEEP

DALMANE® Ⓒⅳ

flurazepam HCl/Roche

STANDS APART

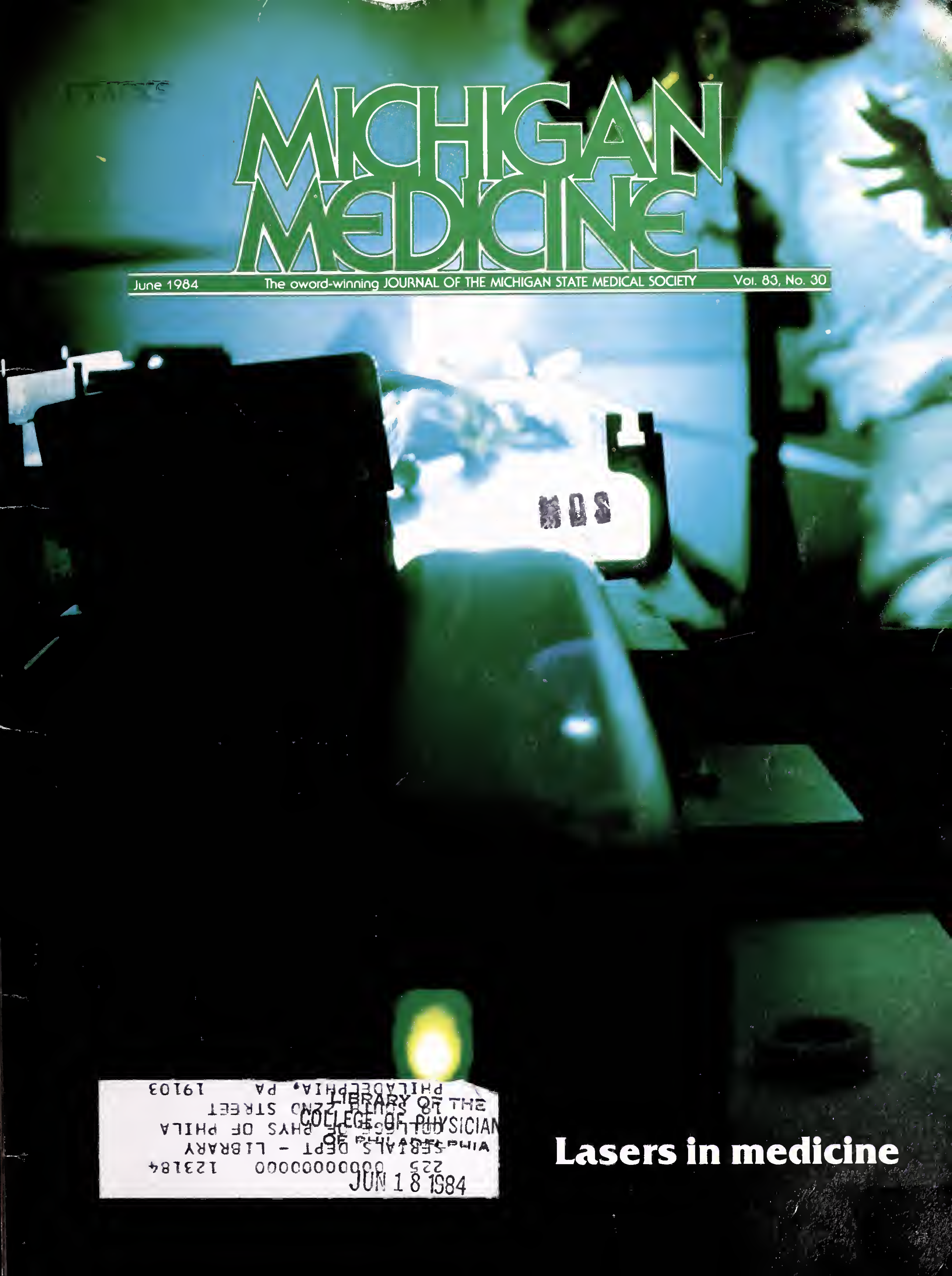
15-MG/30-MG CAPSULES

See preceding page for references and summary of product information.

Copyright © 1984 by Roche Products Inc. All rights reserved.

MICHIGAN MEDICINE

June 1984 The award-winning JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Vol. 83, No. 30



Lasers in medicine

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA
JUN 18 1984

225 00000000000 123184
SERIALS DEPT - LIBRARY
COLLEGE OF PHYS OF PHILA
19 SOUTH 22ND STREET
PHILADELPHIA, PA 19103

The AMA puts current information at your fingertips.

The first nationwide medical information network brings a new dimension to the way in which physicians and other health care professionals keep abreast of the latest knowledge in their profession.

Now, through the use of a low-cost computer terminal or personal computer, you can have instant access to authoritative and up-to-date information. The American Medical Association's computerized data bases place a wide range of professional resources at your fingertips, such as clinical, administrative, medical practice information, and abstracts of current clinical literature. Physicians can earn Category I, Continuing Medical Education (CME) credit using the Massachusetts General Hospital Continuing Medical Education programs or can elect to use the MGH-CME programs as informational updates or refresher courses.

Adding a new dimension to the way in which you communicate is MED/MAIL electronic mail. With the same terminal, you can send messages to your colleagues across the country or across the city . . . in minutes.

Information that could take hours to acquire through traditional channels can now be gathered in minutes, giving you valuable extra time for other important activities. And you can use the medical information network at your convenience, 24 hours a day, from your office, hospital or home.

It's surprisingly economical and professionally indispensable.

GTE Telenet

Medical Information Network

FOR SUBSCRIPTION INFORMATION PLEASE CONTACT
PHYSICIAN SERVICE GROUP, INC.
A member service subsidiary of the
MICHIGAN STATE MEDICAL SOCIETY
EAST LANSING, MICHIGAN

Ellen Vinocur Potash
Telephone 517/337-1351

GTE

Please send me GTE/TELENET MEDICAL INFORMATION NETWORK subscription information.

NAME: ____

ADDRESS: ______________________________________

CITY: _________________ STATE: ________ ZIP: ______

TELEPHONE: (____)____________________________

I have (_______) do not have (_______)
a personal (_______) office (_______)computer .

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL

FIRST CLASS PERMIT # 89 EAST LANSING, MI

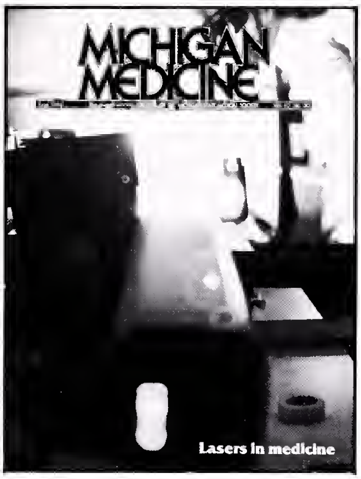
POSTAGE WILL BE PAID BY

Physician Service Group, Inc.
1305 Abbott Rd., Box 950
East Lansing, MI 48823

Attn: EVP

June 1984, Vol. 83, No. 30

MICHIGAN MEDICINE



About the cover

Research scientist Terry Fuller, PhD, tests an experimental long-pulsed neodymium: YAG glass laser in this month's cover photo. The uses of this and other lasers in medicine are the subject of our special report. Cover photo courtesy of Doctor Fuller and Sinai Hospital.

Special report

280 At last November's MSMS Annual Scientific Meeting, Sinai Hospital of Detroit physicians presented a course on the medical use of lasers. The 75 physicians attending the course heard reports from speakers representing several specialties. So that other MSMS members around the state would not miss out on the latest developments in this growing treatment modalilty, our special report this month is presented by many of those same speakers. All our authors are from Sinai Hospital, where much state of the art work is being done with lasers. For details, please turn to page 280; Hugh Beckman, MD; H. John Jacob, MD; Arthur Klass, MD; Eugene Rontal, MD; Michael Rontal, MD; Samuel K. Rosemberg, MD; Frederick Weissman, MD, and Milford Wenokur, MD

By the way, the 1984 MSMS Annual Scientific Meeting is Nov. 13-15 at the Hyatt Regency Dearborn

Features

291 1984 county medical society officers

294 Department of Social Services studying efficacy of Physician Primary Sponsor Plan in Wayne County; F. Charles Peller

298 Tips for offering the Michigan Medical Arbitration System alternative to patients

304 Photo feature: The first AMA National Conference on Child Abuse

306 How MSMS testified for the omnibus medical malpractice bill

308 Details of the recommendations for revamping the Michigan Board of Medicine

Departments

277 Letters

296 Views: Carl F. Hammerstrom, MD

302 Medical newsfronts

312 News; Joyce Crum

314 Category I courses

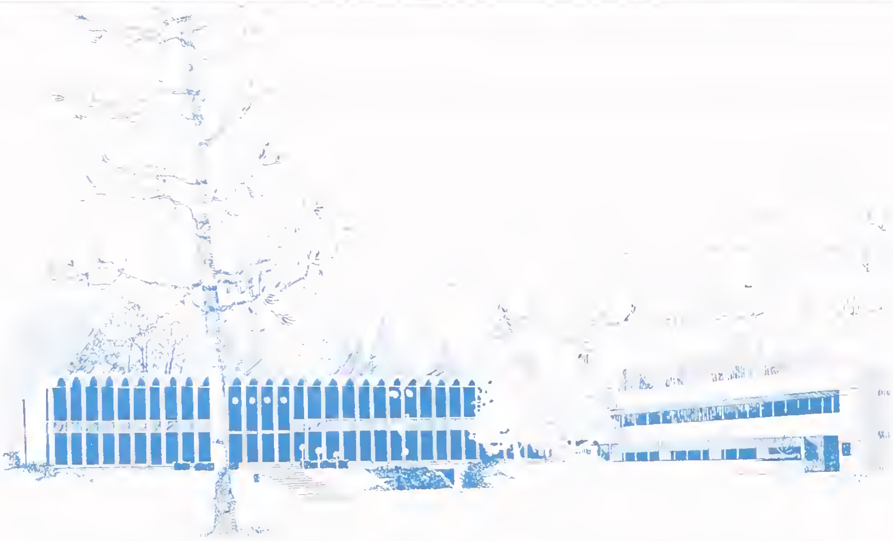
321 Meetings
Ad Index

322 Classified ads

324 President's page; Louis R. Zako, MD

Next month in *Michigan Medicine:*

How some key physician leaders are managing the delicate issues of the physician's relationship to the hospital administration. Our report will offer legal advice and an update on the developing county, state and national hospital medical staff sections. Coming in July!



Michigan State Medical Society

President	Louis R. Zako, MD, Dearborn Heights
President-elect	Richard J. McMurray, MD, Flint
Immediate Past President	Donald K. Crandall, MD, Muskegon
Secretary	Robert M. Leitch, MD, Battle Creek
Treasurer	Leland E. Holly, II, MD, Muskegon
Speaker	Gerald H. Mandell, MD, Detroit
Vice Speaker	Robert D. Burton, MD, Grand Rapids
AMA Delegation Rep.	Richard J. McMurray, MD, Flint

Board of Directors

Chairman	Thomas R. Berglund, MD, Portage
Vice Chairman	Carl A. Gagliardi, MD, Dearborn

District directors

District 1	Carl A. Gagliardi, MD, Dearborn
	James J. Humes, MD, Detroit
	Kenneth J. Ray, MD, Trenton
	Henry M. Domzalski, MD, Detroit
	Arthur A. Ulmer, MD, Grosse Pointe Shores
	Frank B. Walker, MD, Grosse Pointe Farms
District 2	Justin L. Sleight, MD, Lansing
District 3	William D. Walters, MD, Battle Creek
District 4	Thomas R. Berglund, MD, Portage
District 5	Harvey M. Andre, MD, Grand Rapids
	Kornelius Van Goor, MD, Grand Rapids
District 6	Richard L. Rapport, MD, Flint
District 7	Kenneth B. Herrington, MD, Bad Axe
District 8	Jack L. Barry, MD, Saginaw
District 9	Vickers C. Hansen, MD, Manistee
District 10	Charles L. Oppy, MD, Roscommon
District 11	Robert E. Paxton, MD, Fremont
District 12	Carl Hammerstrom, MD, Marquette
District 13	Kenneth E. Rowe, MD, Hancock
District 14	Marguerite Shearer, MD, Ann Arbor
District 15	Billy Ben Baumann, MD, Pontiac
	Frederick W. Bryant, MD, Royal Oak
	Joel W. Clay, MD, Mt. Clemens

Michigan State Medical Society
Warren F. Tryloff, director

Committee on Publications
Harvey Andre, MD, Grand Rapids, chairman
Frederick W. Bryant, MD, Royal Oak
Vickers C. Hansen, MD, Manistee
Leland E. Holly II, MD, Muskegon
Richard L. Rapport, MD, Flint
Marguerite Shearer, MD, Dexter
Louis R. Zako, MD, Dearborn Heights

Editor
Judith Marr

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

MICHIGAN MEDICINE (ISSN 0026-2293) is the official journal of the Michigan State Medical Society, published under the direction of the Publications Committee. Published five times a month, 60 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $30.00; single copies, $1.50. Additional postage: Canada, $1 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to articles, news, exchanges, should be addressed to Judith Marr, advertising inquiries to Joyce Crum and address changes to Peg Berry, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517-337-1351.
©1984 Michigan State Medical Society

HB 4811 adds paperwork

As noted in Health Legislation Update of *Michigan Medicine,* February 1984, HB 4811 has been referred to the House Committee on Public Health. HB 4811 would prohibit a physician from administering or ordering tests for a patient unless he or she obtains the patient's signed consent to the tests on a form that clearly describes each test and states the total cost of each test.

The bill addresses actions on two issues: (1) Patient's informed consent will be required for all tests ordered by physicians. (2) Each patient will have to be informed of the total costs of each test he/she receives.

I strongly believe it to be the ethical responsibility of physicians to provide meaningful information to their patients regarding each and every test or procedure, irrespective of the invasiveness of the specific test or the procedure. The ethically meaningful information should include reasons why the tests are carried out or if they are not carried out.

However, requiring patients to sign a consent to the tests on forms is not going to improve patient care in any sense. On the contrary, it would become a burden to every patient in a hospital setting, as patients will be asked to sign endless forms.

The common advice of lawyers, "Do not sign anything you have not read," would be reminded to many patients by the staff or the concerned friends and relatives and will distress patients, as they, in reality, will not be able to comprehend so much of the medical jargon in so short a time. As Gutheil and Appelbaum put it, "simplification of much medical information to a lay level is either impossible or is so difficult to achieve as to be practically impossible in every day clinical work. Even given the requisite simplification, it is unclear if, in many cases, an individual without a medical education has the context in which to analyze the information. Further, to the extent that illness induces a state of regression in which patients seek a reliable authority figure on whom to depend, they may ignore the information altogether, preferring to ask the doctor at the end of the recitation, "What do you think I should do?"

My clinical judgment on HB 4811 is that it does not improve clinical services to patients but definitely adds medical records paperwork, satisfying legislators that they have done something right for patients, even though patients themselves may not think so.

Regarding the second issue, I believe hospitals and physicians have ethical and legal responsibility to provide information on the total costs of each test and each procedure to all patients before those tests or procedures are carried out. However, I think there should be a more humane and properly dignified approach to this problem. Can you imagine a physician or a staff member before drawing blood for gases and electrolytes in an emergency quoting the prices of blood gases and electrolytes and informing the patient that they cost a total of $29.50? How does this help this patient? It is one thing to have faith in the policies for all cost-containment programs, but it is an entirely different thing where and how it is carried out.

I urge all physicians to write or to call their State legislators to oppose this Bill. If we don't succeed, our patients will surely blame us for it!

Raman N. Bhavsar, MD
President
Northville Psychiatric Association

Unconscionable stuff

The following letter was received recently at MSMS headquarters by staff member John Anthony, with whom the writer has had a long association. We share it with readers as a candid and revealing statement on the times.

On June 1 I shall terminate my services as chief medical consultant of the Disability Determination Service of Michigan. It has been an excellent experience and I have really enjoyed the time that I have spent in Michigan.

I am most grateful for the kindness shown to me and to the DDS by your fine organization. There have been numerous times when your help has "smoothed the road." I am also happy to have been aided by the fine help of many of the physicians of the state. I know that there are some who become a bit piqued by some of our queries, but in many instances it is caused by not knowing what we have to have to be of service to their patients. I usually like to add that it is also possible for a physician to become "disabled" and physicians, too, have been found eligible for benefits. You are well aware that we have little input about what happens to us (exempt the smokers and ethanolics and the "foodaholics"). In all aspects it has been most pleasant and I want to extend my thanks to all.

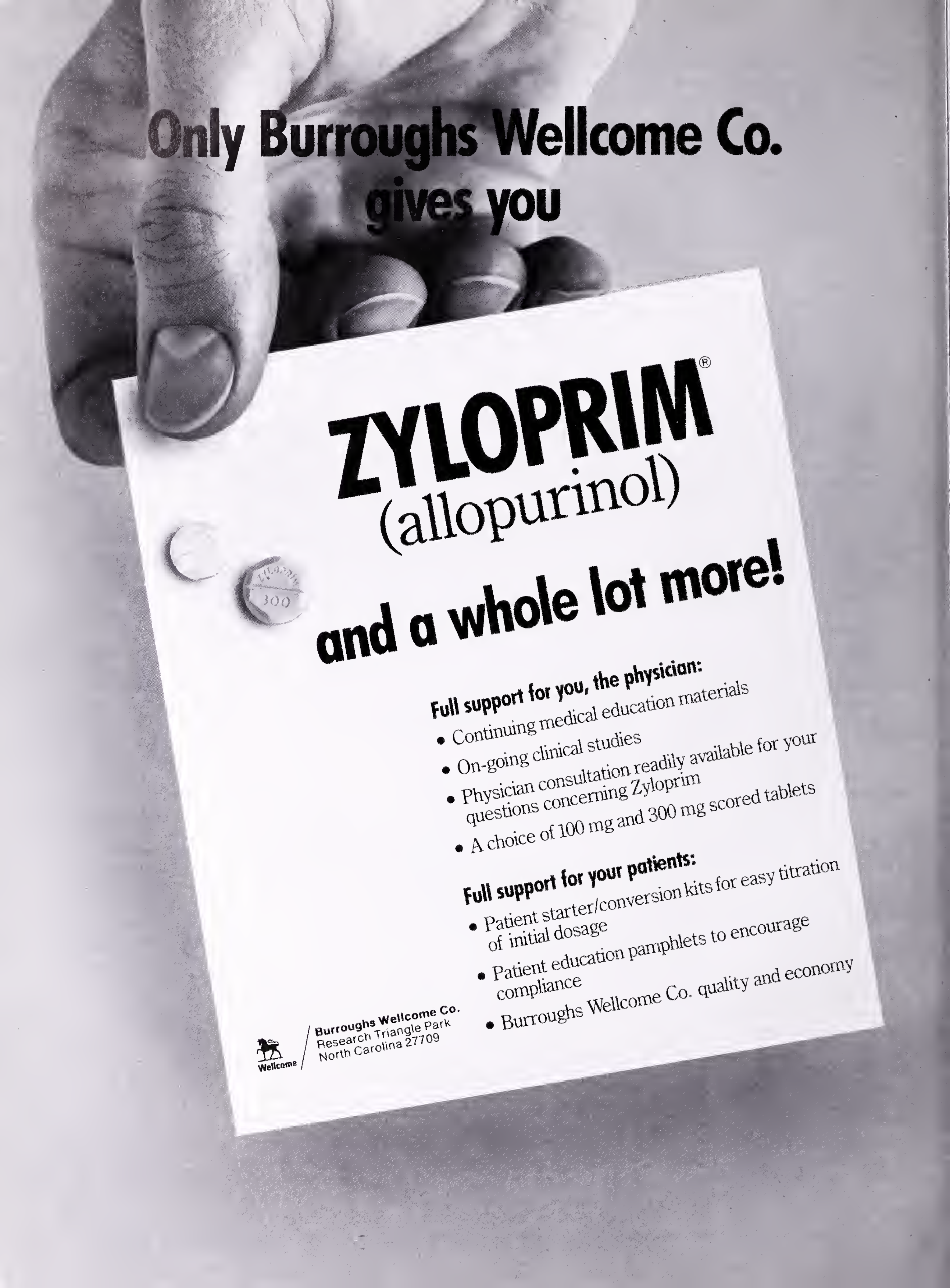
This past Christmas Day I was visiting past patients and friends in Southern Illinois where I practiced before coming up here January 2, 1972. I was visiting a couple and the husband is a retired carpenter. He now makes beautiful mantle clocks out of any old wood he can find. He gave me one made from a stairwell in a home that was demolished about 20 years ago after being on site for over 100 years. 'Tis pretty and I was pleased.

I noted that he had lost the tip end of his left index finger and said, "What happened to you?"

Enjoy (???) the rest.

He told me that he was working out in the shop and a joiner "got hold of his finger" and avulsed the terminal part of the distal phalanx. He came into the house holding his hand and told his wife that they should go to the hos-

Continued on page 279



Only Burroughs Wellcome Co. gives you

ZYLOPRIM®
(allopurinol)

and a whole lot more!

Full support for you, the physician:

- Continuing medical education materials
- On-going clinical studies
- Physician consultation readily available for your questions concerning Zyloprim
- A choice of 100 mg and 300 mg scored tablets

Full support for your patients:

- Patient starter/conversion kits for easy titration of initial dosage
- Patient education pamphlets to encourage compliance
- Burroughs Wellcome Co. quality and economy

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

pital (my home town!!). It was about 3 p.m. She took him out there.

They x-rayed it, (couldn't use their eyes to see that considerable was gone) sponged some blood off his hand and forearm with cotton balls and tap water (according to wife who has worked in said hospital), used a couple of 2x2s and bandaged his hand. They gave him a sling and tetanus shot and sent him to a hospital 17 miles away. The bill from hospital number 1 was $84 (wife said she didn't see a 4x4 and no "irrigation water" was opened).

In hospital number 2 he was told that they were not sure when they could get to him. After two hours wife returned home. The surgery was performed after 11 p.m. Another sling was provided and when he told them he had a new sling down in his room he was told, "Now you have two!" He left the next morning and the hospital bill was only $1,095.55. There were a couple post-op dressings done.

The finger looks good. The flap as well done and I'm sure bone fragments were removed and a nongeur trimmed the terminal phalanx so it was smooth. I said to them, "What did the surgeon charge you for the procedure?" The wife replied, "We haven't received the bill as yet." On the Wednesday after Christmas the wife called and my daughter answered the phone. The wife told Lael, "Tell your dad we got the surgeon's bill. It was $925." (You, too, may now resume breathing if you can!)

These people have Medicare and have supplementary Banker's Life on each which costs an additional $1,400 per year. With the two insurances it will take over $600 out of their bank account to settle for the loss of part of a terminal phalanx of a left index finger!!

There is no exaggeration of facts here, but as far as I am concerned this type of stuff is unconscionable. Perhaps it reflects my age. No one has scrapped harder over the years to keep government out of the field of medicine, but it would seem to me that control is a coming answer and there is going to be a lot of screaming and gnashing of teeth!

I just thought you might react to this as I have. I assure you that I have no intention of seeking a job which would throw me back into the maelstrom.

If you find the example useful, all identifying aspects have been deleted. I smiled as I remembered doing such procedures in office with a local finger block, charged 25 or 30 bucks for the whole deal, never got paid and still had a good result. Do I date myself?

The best of all things good to you and yours in your future endeavors. Again, thanks.

Harry D. Nesmith, MD
Chief Medical Consultant
DDS of Michigan

Nuclear medicine and waste

I am writing to notify your readership about the American College of Nuclear Physicians (ACNP) Professional and Public Information Program and the important issues of Nuclear Medicine and related low-level nuclear waste disposal. The ACNP is striving to educate the non-nuclear medical community and referring physicians about these topics by providing members of our Speakers Bureau — without charge — for major meetings of all medical specialty societies, state and major county medical societies, and other health-related organizations.

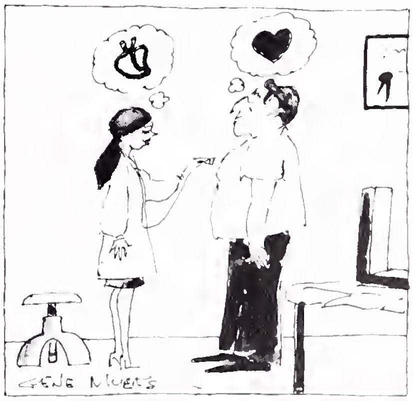
Since almost all medical research involves radioisotope techniques, these topics have a direct impact on all practicing physicians. The proper understanding of Nuclear Medicine and the low-level waste issue is critical to the community of clinical practice and to the future of medicine. Despite its many benefits, the average patient erroneously fears Nuclear Medicine because it involves the use of small amounts of radioactive materials.

The low-level radioactive waste generated by Nuclear Medicine and biomedical research must be transported and disposed of at licensed disposal sites. Currently there is a critical shortage of these facilities. According to the Federal Low-level Radioactive Waste Policy Act of 1980, each state must pass legislation either to enter into a regional compact for disposal or to establish its own facility by January 1986 or the generation of waste within its boundaries must stop.

Although physicians and patients want the benefits of advanced medical technology, many oppose the concept of disposal sites due to their fear of radiation. If, however, the waste management problems are not solved, the practice of Nuclear Medicine and much basic medical research will be in jeopardy. Your prime readership is in a position to disseminate accurate information and address misconceptions when questioned by patients or the public about these issues.

If your readers are interested in these issues or engaging our Speakers Bureau, they may contact me at (202) 857-1191. I will be happy to make arrangements or provide additional information.

Barbara C. Teele
Educational Coordinator
American College of
Nuclear Physicians
Suite 700
1101 Connecticut Ave., N.W.
Washington, DC 20036



LASERS ARE . . .

an exciting alternative to traditional surgery for a growing number of human conditions. Their use today was described by several speakers at a course presented by Sinai Hospital of Detroit at last fall's MSMS Annual Scientific Meeting. Course Director Eugene Rontal,MD, clinical assistant professor, Section of Otolaryngology at Sinai, has obligingly prevailed upon his colleagues, most of them speakers for the course, to share their experiences with the much wider physician audience of *Michigan Medicine.* (Sinai medical staff were a logical choice to present such information, as they have pioneered laser techniques and equipment under the direction of Terry Fuller, PhD, director-chairman of the hospital's Laser Surgery and Photobiology Institute. Doctor Fuller left Sinai at the end of May to head his own laser research and development company near Chicago.) We thank them for writing and invite readers to follow their accounts of this exciting and growing field.

By Eugene Rontal, MD
Michael Rontal, MD, and
H. John Jacob, MD

Use of the CO_2 laser in otolaryngology

The CO_2 laser has demonstrated its usefulness in the treatment of diseases of the ears, nose and throat. The limited tissue destruction by the CO_2 laser and its ability to be delivered by a microscope has enabled its use in many of the inaccessible areas of the ear, nose and throat via the microscope.

One of the most effective ear, nose and throat uses of the CO_2 laser has been in the larynx. Properties of the laser lend itself to adaptation to the microscope which is used frequently in laryngeal surgery. With its low depth of penetration, the carbon dioxide laser allows removal of superficial lesions without damage to the thin laryngeal musculature. Further, the laser's lower degree of scarring and control of bleeding within the larynx allows removal of bleeding lesions which might otherwise be difficult to remove by other manual techniques.

Applications

In the larynx three basic types of lesions can be removed. One type is the discreet benign lesion, including polyps, nodules and granulomas. The lesions are removed mainly for the cosmetic voice problems which they cause. Therefore, there is a premium on being able to remove the lesion without scarring the underlying pharyngeal musculature during the biopsy. The laser achieves this under the microscope by precisely cutting or vaporizing the lesion from the submucosal tissue. Even small but functionally detrimental nodules can be removed. In the case of granulomata the laser allows removal with a minimal amount of scarring which might cause reformation of the granuloma.

A second application of the laser in the ENT is in the treatment of airway obstruction within the larynx. Congenital webs, subglottic or posterior subglottic stenosis or even bilateral fixation of the vocal cords can be treated endoscopically with the carbon dioxide laser without performing major external procedures. The laser itself produces less scarring and therefore less reformation of the original problem.

The result in this type of case varies with the extent of the scarring and stenosis of the tissue around the vocal cords. Today, with more long term endotracheal intubations, both extra- and intra-operative, the incidence of these problems has accelerated. Before the laser, the only solution to this dilemma was a significant external resection or permanent tracheostomy.

A third area for laser use within the larynx is the treatment of bleeding lesions. The more bleeding there is, the less accurate microscopic procedures can be. With the laser, small bleeding vessels can be controlled by the thermal effect of the beam, allowing resection without excessive tissue destruction and scarring.

The best example of this usage is in the treatment of vocal cord papillomata. These multiple warty lesions are extremely hard to remove by conventional manual techniques. The laser affords unsurpassed access for removal with a minimal of tissue destruction. The laser has developed as the treatment of choice for these lesions.

The laser has beginning applications within the nose. Treatment of recurrent diseases that heretofore may have required major resections can be done with the laser. Such diseases as choanal atresia, benign neoplasms and obstructive scarring can be treated with the CO_2 laser. Where control of bleeding is necessary, the argon laser can be utilized to coagulate larger submucosal vessels. Such disease as hereditary hemorrhagic telangiectasias can be controlled by this technique. Sometimes, it is the only method available to these people who have numerous transfusions and operations to control their bleeding.

Other uses

The otolaryngologist also finds great usefulness for the laser within the tracheo-bronchial tree. Some lasers may be delivered by a small fiber inside of a flexible bronchoscope. With this laser in place within the flexible scope, inaccessible lesions which may be obstructing the trachea and bronchi may be approached. This is particularly useful in unresectable carcinomas which may cause suffocation and airway collapse. Genuine palliation and prolongation of life may be achieved by this technique. It can also be used for bleeding areas within the lower airway to coagulate blood vessels or to remove vascular lesions or stenoses.

Newer developments with the laser in otolaryngology are forthcoming and revolve around the ability to deliver the CO_2 laser in accessible areas of the head and neck. Diseases such as recurrent CA of the base and of the skull can be today removed with the carbon dioxide laser. With the development of the CO_2 fiber laser, lesions of the nasopharynx, eustachian tube, sinus antra and esophagus all may be removed with this technique.

Doctors Rontal and Jacob are in the private practice of otolaryngology, head and neck surgery in Southfield.

By Samuel K. Rosemberg, MD, FACS

CO_2 lasers in urology

Our experience over the past eight years with the use of lasers in urology has been convincing. It has broadened and improved the treatment of some specific pathologic conditions in our field.

In 1976, for the first time we established the difference between continuous wave and rapid superpulsed CO_2 laser in bladder surgery. We found that this type of coagulating energy appears to be an attractive method for eradication of superficial bladder tumors, since absence of scar appears to be a desirable feature of laser surgery. Since that time, several reports using different types of lasers, such as Nd-Yag and Argon, have appeared in the literature suggesting the following advantages: (a) Precision of application, (b) reduced bleeding and interruption of lymphatic drainage, (c) reduction of tumor cell implantation, (d) no need for general anesthetic, (e) avoidance of postoperative catheter drainage, (f) homogeneous transmural coagulation of tumor tissue.

Nevertheless, selection of patients is important, as tumors of more than 3.0 centimeters in diameter are not effectively treated by this modality. Future development of fiberoptic systems able to convey the CO_2 laser through a liquid medium will certainly improve the management of bladder neoplasms over the well known treatment modalities.

After treating 75 patients, we have established guidelines for the treatment of recurrent urethral and external genital condylomata. Of these patients, 88 percent responded to a single laser treatment with complete eradication, lack of stricture formation, and minimal postoperative discomfort. This form of therapy appears to be safe for eradication of superficial mucosal lesions, and can be used either as a first choice of treatment or as an adjunct in those patients not responding to other well known treatment modalities. Laser ablation of these lesions can be performed under local anesthesia.

The laser surgical technique is important. Complete eradication through vaporization of a particular pathologic process will depend upon the adequacy of execution. In 1980, we described the vertical-horizontal-oblique technique which assures uniform ablation of tissue with exceptional cosmetic results for any type of external genital lesion.

Disease entities such as balanitis xerotica obliterans and erythroplasia of Queyrat have been aggressively treated in the past with less than adequate results. The CO_2 laser with its continuous wave and rapid superpulsed modes has proven to be superior, offering preservation of anatomical landmarks and function, and excellent cosmetic results.

Pioneering the field of clinical use of CO_2 laser in renal surgery, we have found this tool exceptional. Depending on the thermal tissue behavior, the laser can be used to either heat and coagulate, produce a surgical incision, or vaporize tissue by ablation. Clinically translated, it means the capability to control bleeding, to incise kidney parenchyma, and, coupled to the growing field of endourology, the ability to treat renal collecting tumors in those patients who are poor surgical risks, who have impaired renal function, or those who harbor a neoplasm in a solitary kidney. At the present time, our experience has included the management of staghorn calculous disease by anatrophic nephrolithotomy, treatment of renal cell carcinoma, congenital arteriovenous fistula, and duplication anomaly treated by hemi-nephrectomy. Our findings suggest: (a) Significant reduction in blood loss, (b) shortening of operative time, and (c) preservation of the functional integrity of the remaining renal segment, with the possibility of sparing nephrons and tubules.

The laser used for surgical purposes must coagulate tissue by working below the threshold of vaporization. This capability has been used by us to produce fusion coagulation of collagen and tissue coaptation in the performance of CO_2 laser vasovasostomy. The advantages found with this procedure are: Speed of performance, consistency in surgical technique, and availability to surgeons not trained in microsurgery. Active clinical trials are underway with this new procedure at our institution, and results will be made available in the near future.

Our experience to date with the clinical application of the CO_2 laser in the field of urology has been unique, demonstrating a noticeable superiority over well known treatment modalities. Only high cost and lack of experience remain as obstacles in the widespread use of this technology in medicine.

(Bibliography available from the author.)

Doctor Rosemberg is a diplomate of the American Board of Urology. He is with Urology Associates, PC, of Southfield, Warren and Troy.

By Fredrick Weissman, MD

The use of the laser in plastic surgery

In June 1979 at Sinai Hospital, a meeting was held with the Laser Research Committee to propose a study involving the use of lasers in plastic surgery. It was unique to Sinai Hospital at that time that argon, carbon dioxide, ruby and neodymium: Yag laser machines were present under one roof.

The study proposed that hemangiomata and tattoos have sample areas treated by all four modalities. Evaluation would be made to determine whether there was a difference in the results gained by using the various laser machines. Within a few months into the study it became clear that the argon laser was more effective in the treatment of port wine stains and the carbon dioxide laser was most efficacious in the treatment of tattoos. Since that time this has been the regimen of treatment.

Hemangiomata

It has been our observation, and that of others, that the more superficial and more mature hemangiomata respond best to the argon laser. Those that extend deep in the dermis, do poorly. We have arbitrarily limited our patient selection to adults who can be done under a local anesthesia as outpatients. Large, extensive lesions obviously would require multiple treatments.

Consultation:

Prior to treatment, the patient is interviewed and the factors concerning the port wine stain that are bothersome to the patient are elicited. The technique of laser surgery is carefully explained. The possibility of excessive scarring, only slight change or even no change in color is emphasized to the patient. Thus, it is generally suggested that a test area be treated initially. This would be an area approximately four to six centimeters and preferably where it could be masked by hair or cosmetics, if the end-result turns out unfavorable.

Technique:

The patient is brought to the laser surgery operatory and positioned on the operating table in a comfortable position. Protective goggles are supplied to all persons in the room. The area for treatment is marked and infiltrated with ½ percent xylocaine without epinephrine.

Using 1.0 to 1.2 W of power, a spot size of two millimeters and continuous mode, the wand is held two to three centimeters from the skin and passed at a uniform rate over the hemangioma so that blanching is obtained.

Post-operative:

The area of treatment is bandaged with a thin film or bacitracin or neosporin ointment and dry gauze. The patient is able to leave immediately after treatment is finished. Bathing is allowed and followed with fresh bandaging. The patient is cautioned not to tear or disturb the crusts that form, but to let them separate spontaneously. After separation, the area is generally pink, similar to the erythema of a thermal burn. This pinkness fades with time and the area should be protected from the sun by cover or sunscreen.

Results:

Desirable results vary from 51 percent to 73 percent. Most lesions can be lightened in color and hence their cosmetic deformity is reduced. Unfavorable results include excessive scarring in approximately 10 percent.

Tattoos

Artistic or decorative tattoos seem to be increasing in popularity again. Most are professionally obtained and are multi-colored. The amateur tattoo is usually of only one color and characterized by uneven placement of the pigment in the skin, often going into subcutaneous depth in some areas. This is of great importance because the relationship between scarring and the depth to which the lasing must go to plane away the pigment is a direct one.

Technique:

The area for treatment is outlined and anesthetized with xylocaine with epinephrine. Using 10 to 15 W of power the entire tattoo, including areas of normal skin are lased with the CO_2 laser. The area is then forceably wiped or abraded with a sponge to remove the outermost layer. This now brings out the pigment more vividly. Again the area is lased concomitant with the spraying of ethyl chloride to chill the skin and reduce the heat absorbed by the skin adjacent to the vaporized pigment of the tattoo. This seems to reduce the amount of thermal injury and thus reduce the tendency to scarring. This method is repeated until all or nearly all of the pigment is removed.

Continued on page 284

Doctor Weissman is clinical assistant professor, Department of Plastic Surgery, Sinai Hospital of Detroit.

SPECIAL REPORT/Continued

By Arthur Klass, MD

Lasers in gastroenterology

UGI bleeding from peptic ulcer accounts for more than 100,000 hospital admissions per year. Further bleeding occurs in critically-ill patients in hospitals for other illnesses. Despite the advances in critical care medicine and improved diagnostic capabilities offered by fiberoptic endoscopy and radiologic techniques, the mortality from UGI bleeding has remained about 10 percent for the past 30 years.

Spontaneous cessation of bleeding occurs in 85 to 90 percent of such patients. Emergency surgery for bleeding peptic ulcer has a 15 to 28 percent mortality. Elective surgery in similar patients has a 0.4 percent to 3.0 percent mortality. In the recent past, routine emergency endoscopy for patients with upper GI bleeding has been denigrated because it was not shown to improve patient morbidity or mortality.

However, the advent of methods of transendoscopically controlling such bleeding lesions holds the promise of improving survival rates, decreasing morbidity and decreasing the duration of hospitalization and cost. General anesthesia is ordinarily not required except for patients who are in cardiopulmonary or hemodynamic instability.

In late 1976, Terry Fuller, PhD, and I collaborated on investigating the safety and efficacy of Argon and Nd:Yag lasers in the control of bleeding lesions in the GI tract. We compared thermal-tissue effects of the two lasers using various power times time sequences, with the spot size held constant. The visible blue-green Argon laser energy is highly absorbed by red pigment and thus, does not penetrate tissues as deeply as the Nd:Yag lasers, the penetration of Argon:Nd:Yag being about 1:4. All things being equal, then, Argon would be safer. But, in the presence of blood, the absorption of the energy by the superficial blood minimizes a thermo-coagulating effect on the bleeding vessel and thus is less effective in controlling bleeding.

We concluded, as did many investigators, that Argon is preferable in non-bleeding lesions, i.e., angiodysplasia, telangiectasia of Osler-Weber-Rendu disease, non-bleeding visible vessels in ulcer craters, and sessile polyps in familial polyposis coli, but the Nd:Yag laser is more effective in the presence of actively bleeding lesions and larger tumor masses.

In 1978, we began clinical trials and have since treated more than 250 bleeding episodes in 220 patients. Most of the repeat treatments have occurred in patients with Osler-Weber-Rendu disease and erosive gastritis.

Case selection has been as follows: Massive upper GI bleeding that has not responded to conventional methods; clinical shock; usually evidence of persistent bleeding for more than six hours; recurrent bleeding episodes from vascular malformations of the upper or lower GI tract, usually in elderly patients; poor surgical candidates because of severe medical problems with slow GI bleeding; patients with spontaneous cessation of massive upper GI bleeding found to have visible vessels or other stigmata of recent hemorrhage on endoscopy (based on evidence that almost all patients who re-bleed from peptic ulcers have visible vessels, and more than one-half the patients with visible vessels re-bleed). A number of the cases were intensive care unit patients with severe underlying medical-surgical problems who were extremely grave anesthetic-surgical risks. At least six patients were on ventilators.

We have safely and effectively treated the following bleeding conditions of the GI tract: traumatic mucosal laceration of the upper third of the esophagus; Mallory-Weiss tears; hemorrhagic gastritis; angiodysplasia of the stomach actively bleeding and quiescent; peptic ulcers of the stomach and duodenum actively bleeding and with visible vessels or other stigmata of recent hemorrhage; Osler-Weber-Rendu lesions of esophagus, stomach and duodenum; bleeding gastric polyp; angiodysplasia of the colon.

Fiberoptic endoscopy will reveal the site of bleeding more than 90 percent of the time. The lesion must, of course, be accessible to the laser beam, ideally en

---

Doctor Klass is clinical assistant professor of medicine at Wayne State University School of Medicine, and attending physician, Sinai Hospital of Detroit.

PLASTIC SURGERY/Continued

Post-operative:

The wound is dressed with antibiotic ointment and gauze and wrapped with an Ace bandage. Bathing and dressing changes until healing is complete are necessary for approximately three to four months. The patient is advised that he may see tattoo pigment weep through onto the dressing. The initial healed wound is generally pink early and gradually blanches to a whiter than normal skin appearance after one year.

Results:

The level of patient satisfaction is extremely high; even in cases where some hypertrophic scarring occurs. This occurs in about three percent of cases, but improves with the continued use of the Ace bandage. Patients are particularly pleased that the method does not involve skin grafting or suturing and can be done on an outpatient basis.

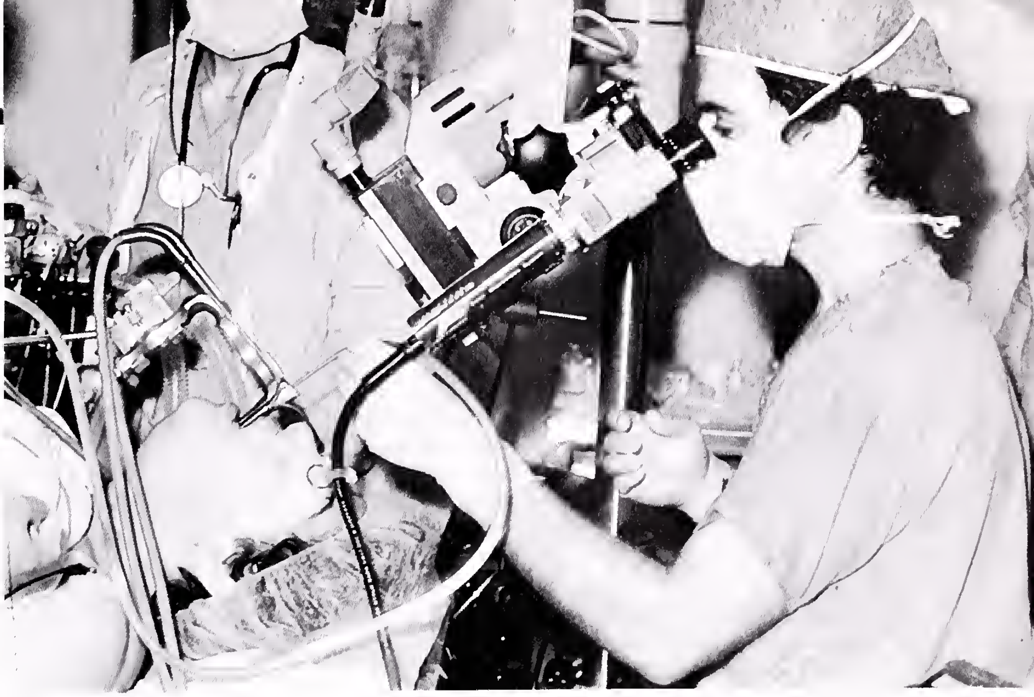
face, so that the lesion can be circumferentially thermocoagulated. This in part explains why bleeding lesions in the duodenum are controlled less often than in the stomach. Massively bleeding duodenal ulcers may be impossible to visualize because of the difficulty in evacuating the blood in a tubular organ rapidly enough to visualize the vessel. In addition, a small number of lesions will be obscured by flexures or edematous folds, especially in the duodenal bulb and occasionally the gastric antrum.

In brief, only lesions which are technically accessible and which can be visualized are amenable to transendoscopic therapeutic endeavors. Large clots may fill the stomach and are not always easily removed. Vigorous lavage with large bore tubes is often required.

Our results, and those of others, is that with experience, more than 90 percent of bleeding gastric ulcers and more than 80 percent of bleeding duodenal ulcers are controlled with Nd:Yag laser photocoagulation. The rebleeding rate is about 15 percent.

Depending on the location of the lesion, the amount of laser energy delivered in the initial session and the clinical condition of the patient, retreatment may be performed and most such bleeding episodes will be staunched. In our series of more than 120 bleeding peptic ulcers, three duodenal ulcers were inaccessible and could not be treated. One gastric ulcer with a visible vessel rebled 18 hours later and was operated before it could be retreated. Several patients oozed for several days post-treatment, were observed and the bleeding ceased. Following treatment the patients are treated in the usual manner with antacids and H_2-blockers.

Patients with Osler-Weber-Rendu disease and angiodysplasia of the UGI tract or colon can be treated as outpatients if they are clinically stable. Ideally, Osler-Weber-Rendu patients with many telangiectasia are treated on a regular basis in an effort to reduce transfusion requirements and hospitalization, based on the presumption that each telangiectasia that is ablated is one less to potentially bleed. This seems to be the case.


Eugene Rontal, MD, uses a carbon dioxide laser to treat disease of the larynx and pharynx.

Bleeding from ulcerating malignancies of the UGI tract presents another problem. Malignant stroma may not constrict in the same manner as non-malignant tissue, tumor vascularity is unpredictable and after successful control of one bleeding site, sloughing of necrotic tissue may provoke further bleeding. We were unable to stop massive bleeding in two cases of bleeding gastric adenocarcinomas.

The risks of transendoscopic laser photocoagulation, in addition to the usual risks of endoscopy in an actively bleeding individual, are:

(1) Perforation in about one to three percent of published series with the Nd:Yag laser. The hole is usually less than 2 mm and the results of emergency surgery are comparable to or better than spontaneous perforations.

(2) Bleeding may be worsened — a non-bleeding visible vessel may be provoked; if not controlled, a semi-elective case may become an emergency; more than 90 percent of the time, however, the bleeding is controlled.

As indicated above, angiodysplasia is ideally treated with the Argon laser. Not only is the red lesion ideally suited to the Argon wave length, but the tissue paper-thin wall of the air distended cecum is uniquely susceptible to the risk of perforation when the more deeply penetrating Nd:Yag laser is used. More than 20 such cases have been followed for more than one year with no further bleeding. Several patients who rebled were retreated and have not bled again.

One must be cautiously optimistic about such vascular lesions, as they may be multiple, all of them may not be seen on a particular colonoscopy and the photocoagulated lesion may not have been the one that caused the bleeding. However, this initial excellent success rate is encouraging.

The ability of lasers to destroy malignant tissue has been known for 20 years. Gynecology, urology, neurosurgery and other specialties have destroyed and vaporized tumors with Argon, Nd:Yag and CO_2 lasers (a flexible transendoscopic fiberoptic delivery system is not yet available for the CO_2 laser, but my associate, Doctor Fuller, has recently de-

By Hugh Beckman, MD

Lasers in ophthalmology

The unique construction of the eye whereby the visible spectrum of light is transmitted through the optically clear media and becomes absorbed by the pigmented structures within the eye led ophthalmic investigators into the development of medical applications almost immediately after the production of lasers in the early 1960s. Due to this headstart, lasers and their applications in ophthalmology are at this time more numerous and more sophisticated than in any other medical specialty.

The laser that has become the workhorse in ophthalmology is the argon laser. It was first utilized in welding and ablative applications in the retina for such conditions as diabetic retinopathy, vein occlusions and retinal tears. More recently, other retinal applications have been found in the treatment of some muscular degenerative disease associated with abnormal retinal vascular nets.

All of the above mentioned conditions were either poorly treated or untreatable prior to use of the laser. The treatment of diabetic retinopathy by laser has turned a hopeless condition causing visual loss and blindness in thousands into one with a reasonably good prognosis, if treated in time. The krypton laser, with its red hemoglobin penetrating beam, has recently become available as a valuable adjunct to the argon laser in the treatment of many of these retinal conditions.

Shortly after the impact of photocoagulation in the treatment of retinal disease, attention was transferred to the laser treatment of glaucoma. By shining the laser beam through the transparent cornea onto the pigmented surface of the iris, a hole could be drilled through the iris from the anterior chamber to the posterior chamber creating a shunt for aqueous humor flow, enabling a non-surgical treatment for pupil block, angle-closure glaucoma. This has now ap-

Continued on page 288

Doctor Beckman is chairman, Department of Ophthalmology at Sinai Hospital of Detroit.

GASTROENTEROLOGY/Continued

veloped such a system). Since 1981, a number of centers in Japan, Europe and North America have reported successful palliation of obstructing malignancies of the esophagus with the Nd:Yag laser.

In 1983 we started treating obstructing carcinomas of the esophagus, stomach and duodenum with the Nd:Yag laser. Patients are often malnourished, have inoperable lesions, have lesions which have recurred after radiation and/or chemotherapy, often have chronic lung disease and have almost total esophageal occlusion. Most are squamous cell carcinomas of the esophagus, but one-third are adenocarcinomas of the cardia of the stomach, invading the esophagus.

Carcinoma of the esophagus has a dismal course with a less than five percent five-year survival rate. Current methods of palliation consist of resection of the distal lesion, radiation and/or chemotherapy for non-resectable or more proximal lesions, bougienage and prosthetic stents to establish a patent lumen. Pharyngostomy may be needed to evacuate secretions and gastrostomy is used for nutrition.

As recently suggested by Fleischer (*Gastroenterology*, September 1983), endoscopic laser palliation obviates the risk and morbidity of surgery and general anesthesia; does not have the therapeutic lag of radiation and/or chemotherapy; is performed under direct visualization; has good patient acceptance and permits retreatment if tumor recurs. It is no more than a method of establishing luminal patency, often to 10 to 11 mm, so that saliva can be swallowed and the pleasures of oral nutrition sustained to some degree. It should be regarded as complementary to standard methods of palliation.

Thus far we have achieved such palliation in eight cases of esophageal and esophagogastric carcinomas, one case of obstructing leiomyosarcoma of the stomach and one case of carcinoma of the antrum invading and obstructing the duodenum.

It must be emphasized that the methodology is rapidly evolving. Techniques for mechanically removing tumors with large bite forceps, using hydrostatic balloon dilators, rigid tapered bougies and thinner therapeutic endoscopes with empirical modifications of techniques, is allowing successful treatment in shorter periods of time. Retreatment at early evidence of recurrence may be done on an ambulatory basis. The reported complications of this method, in addition to the usual concerns of aspiration and anethestic complications, consist of esophagotracheal fistulas, mediastinal or abdominal perforations and massive bleeding.

The effectiveness of endoscopic laser energy in de-obstructing carcinomas of the GI tract, and esophagus in particular, has been shown. A larger experience will determine its ultimate safety and role in the palliation of this most dreadful lesion.

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android® /5 mg. Buccal /10 mg. Oral /25 mg. Oral

Methyltestosterone U.S.P. Tablets

ANDROID® /F

Fluoxymesterone U.S.P. Tablets, 10 mg.

proached being the standard therapy for the condition and is performed under topical anesthetic on an outpatient basis.

By transmitting the laser beam through intact conjunctiva and sclera and having it absorbed by the ciliary body (the source of aqueous humor production) of the eye, ablation of the ciliary body with subsequent decrease in aqueous humor formation can be performed in eyes that are intractable to other medical and surgical therapy in the treatment of severe glaucomas that were heretofore almost impossible to control. This procedure called transscleral laser cyclocoagulation is now performed with ruby and neodymium solid state lasers.

By aiming the laser beam through the cornea onto the trabecular meshwork (where aqueous is filtered from the eye), the meshwork can be stretched open, enhancing the ability of the aqueous to leave the eye. This permits many patients who heretofore required filtration surgery to come under control without the need for surgery. This procedure, which is performed on an outpatient basis, has in the last five years become the standard therapy after medical failure and is used to avoid glaucoma surgery if possible.

An exciting development in ophthalmology in the last two years is the use of the high-powered neodymium: YAG laser, which produces millions of watts of energy in nanoseconds or picoseconds. These super high power bursts result in tissue disruption due to optical breakdown of the tissue and have enabled the ophthalmologist to cut structures inside the eye such as the posterior membrane (capsule) left after extracapsular cataract surgery, vitreal strands and iris adhesions without invading the eye with a surgical instrument. These procedures, although relatively new, have already resulted in thousands of patients being spared the necessity for surgical intervention. They are performed on an outpatient basis under topical anesthetic and require only a few minutes of time.

The carbon dioxide laser with its ability to cut all tissue hemostatically has been used in ophthalmology to perform filtering glaucoma surgery and more extensively in lid plastic surgery. Hemangiomas, basal cell carcinomas and xanthalasma are among the tumors treated by this microscopically controlled cutting beam. Blepharoplasties can be performed hemostatically.

The 6300 angstrom band of the dye laser has been used to activate hematoporphyrin derivative that has been retained by ocular tumor tissue such as choroidal melanoma and basal cell carcinoma. This hematoporphyrin derivative is retained by tumor tissue 72 hours after ingestion but is not retained by normal tissue that long. Cellular HPD, when activated by the 6300 angstrom light, forms an oxygen singlet that is toxic to the cell membrane, resulting in autonecrosis of the tumor tissue. This autoselective destruction of tumor tissue opens a whole new field of phototherapy, not only for ophthalmology, but for every other medical specialty. It spares normal tissue due to the relationship of a specific wavelength of light to substances selectively retained by tumor tissue.

Recently, experimentation with excimer lasers, specifically at 1930 angstrom in the ultraviolet range, introduced to medicine the concept of the photodisruption of molecular bonds by laser energy. This “cutting” takes place in a very controlled manner with no charring or tissue shrinkage. Because no hemostasis occurs, the anticipated early applications of excimer lasers in ophthalmology are anticipated to be in the field of corneal surgery, where the tissue is avascular.

I think one can see from the above short summary the exciting and diversified impact that lasers have made in ophthalmology in only the last 20 years. As the whole laser field is in its infancy, one can only wonder at what the future holds with these devices that are so suitable for use in ophthalmic therapy.

By Milford Wenokur, MD

Laser and anesthesia

Close interplay between surgeon and anesthesiologist is necessary during several types of laser surgery, but is nowhere more apparent than during intralaryngeal laser surgery with the CO_2 laser.

The necessity for sharing the upper airway in its narrowest portion had led to a myriad of techniques for induction and maintenance of anesthesia for laryngeal surgery. The use of the CO_2 laser for laryngeal surgery in 1965 by Jako added several challenging problems for the anesthesiologist.

General anesthesia for laser microlaryngeal surgery presents a number of requirements. Local anesthesia can be omitted from consideration because the combination of moving vocal cords with the unpredictable conduct of an uncomfortable patient makes the risk of laser damage to uninvolved tissues too high.

The conditions considered necessary include: (1) unconsciousness with immobility of the patient, (2) adequate oxygenation and elimination of CO_2 without excessive pressures on the thorax, (3) motionless vocal cords, (4) absence of tissue trauma, (5) excellent surgical visibility with access to the entire field by the laser, (6) protection from blood or vaporized tissue being aspirated into the lung; particularly avoiding pushing papillomatous material downward and seeding the trachea and bronchi, (7) removal of smoke and debris from the larynx, (8) fire protection (the big difference between laser and ordinary laryngeal surgery), (9) rapid recovery of consciousness and the cough relfex, (10) relative simplicity.

Two techniques

Of the many techniques used for anesthesia during laryngeal surgery, two methods seem to be useful for laser surgery: The use of a cuffed endotracheal tube or the use of jet ventilation.

With the use of a small endotracheal tube, the anesthesiologist has total control of the airway from the onset. Adequate oxygenation can be achieved. The cuff can prevent aspiration of blood and debris. Expired gases are not dependent on the lumen of the airway for their elimination.

However, the tube, even though smaller than that used with nonlaryngeal surgery, does impede visibility and access, particularly with posterior lesions. More importantly, the size of the tube makes it vulnerable to effects of the aberrant laser beam with the resultant explosion hazard. How we cope with the fire hazard will be mentioned shortly.

Jet laryngoscopy techniques are derived from the Sanders Venturi apparatus first described in 1967. A rapidly moving stream of air from a jet causes negative pressure proximally, with entrainment of air which enters the lungs and ventilates the patient. Several techniques had been in use, but all had drawbacks when considered for laser microlaryngeal surgery.

At Sinai, a Dedo laryngoscope was modified so that an 8 to 12 F woven nylon urethral catheter would pass down a special lumen starting on the side of the laryngoscope and ending up inferiorly. The smaller size catheter is used for children. General anesthesia with thiopental and muscle relaxant is used.

Arterial blood gas analysis showed more than adequate oxygenation and CO_2 elimination. The great majority of patients had PO_2s over 400 torr. Several patients with severe pulmonary disease and subnormal preoperative PO_2 had intraoperative PO_2s over 300 torr, demonstrating that obstructive or restrictive pulmonary disease per se did not contraindicate this technique.

400 patients

Since our initial study, we have used this technique on 400 patients, with excellent results in patients from three to over 80 years of age. It is felt that this method fulfills nearly all of the requirements of anesthesia for laser microsurgery. Surgical access is unexcelled. The inflation catheter is almost totally out of view and difficult (but not impossible) to hit with the laser beam.

The rigid catheter is held in place by its channel in the laryngoscope and cannot move around, traumatizing tissue or having its lumen occluded against the tracheal wall.

The jet stream is distal to the operative site; thus it will not blow debris into the distal airway. The exhaled gases, incidentally, efficiently remove smoke from the operative field and it's unnecessary to keep a suction tube inside the laryngoscope.

Excessive pressures distal to the vocal cord can easily be developed with the jet catheter with development of pneumothorax. This can be avoided by use of minimal ventilating pressures and by keeping the patient totally paralyzed while using jet ventilation.

With laryngoscopy, hypertension is common and can be a problem during prolonged laser procedures. Deep anesthesia, pretreatment with Propranolol, and administering morning doses of their medication to hypertensives will decrease the incidence, but the occurrence of hyperten-

---

Doctor Wenokur is associate professor and attending staff at Sinai Hospital of Detroit.

Sinai Hospital of Detroit is not the only Michigan medical center where lasers (laser is an acronym for light amplification by stimulated emission of radiation) are being used by physicians.

In a cursory survey, MSMS staff was able to determine that lasers also are in use at the following locations:

Henry Ford Hospital, Detroit, where Paul Kvale, MD, performs laser resection of endobronchial tumors, using the neodymium: YAG laser.

The University of Michigan Hospital, Ann Arbor, where Martin E. Pearlman, MD, uses the laser in ophthalmological procedures.

Genesee Memorial Hospital, Flint, where Stephen Kalstein, MD, also is using the neodymium: YAG laser for ophthalmological work.

And, again, at William Beaumont Hospital in Royal Oak, where Frederick W. Bryant, MD, has been using neodymium: YAG lasers recently for treatment of glaucoma, diabetes of the retina, and secondary cataracts.

Are there other physicians who are using lasers in their practices? If so, *Michigan Medicine* would like to hear from them. We would like to share any reports of such technical capabilities with physicians around the state, to aid in information-sharing and possible referrals.

If you would like to share development of such technical expertise with your colleagues, please write The Editor, *Michigan Medicine*, 120 W. Saginaw St., East Lansing, MI 48823.

sion cannot be totally prevented.

Prevention of accidental laser impaction on both OR personnel and patient is essential. With the CO_2 laser, the only thing the OR personnel must do is wear glasses. This will protect the eyes from aberrant laser beams. Otherwise, only the surgeon's finger is at risk while he manipulates instruments within the larynx.

Real risk

The patient, however, is at a real risk. CO_2 laser radiation is absorbed by the cornea and can cause corneal opacification. The patient's eyes must be covered with moist pads to prevent their being injured.

The real problem, however, is in the larynx and trachea. It has been shown that a CO_2 laser can burn through an endotracheal tube in one second at full power, turning it into a blowtorch until the flow of gas is turned off. Numerous reports of fires have been published.

Several methods are advocated to cope with the fire hazard during laser microlaryngeal surgery. Basically, one can either isolate the flammable material (i.e., the endotracheal tube) from the laser by moist sponges or avoid the use of flammable materials. There is a commercially available flexible metal endotracheal tube and also one made of silicone which is fire resistant. We prefer to use a jet catheter and thus far, have not been able to obtain them in a nonflammable material. We wrap our catheters with aluminum foil, exercising care to leave no bare spots on which the laser may impact.

Some have advocated the use of low oxygen environment (less than 50 percent) to decrease flammability, but it has been shown to be of limited value. The use of helium along with reduced O_2 to decrease flammability does, however, show some promise.

Endobronchial and endotracheal YAG laser surgery of obstructing lesions, usually carcinomas, has been shown to be a worthwhile palliative procedure. Frequently these patients are critically ill with severe hypoxemia and respiratory distress.

They are usually operated under local anesthesia. Ten to 15 cc of four percent Lidocaine is nebulized via an ultrasonic nebulizer about fifteen minutes before the procedure and the base of the tongue sprayed with 10 percent Lidocaine. Mild sedation is also administered, usually droperidol, along with small increments of Ketamine.

Laser ablation

The procedure of laser ablation of the endometrium presents one unusual problem for the anesthesiologist, the possibility of fluid overload from the saline bathing the uterine cavity during the procedure being systemically absorbed. This has become unusual with greater experience and can be treated with IV furosemide.

The biggest challenge for the anesthesiologist during laser endometrial ablation comes not from the procedure itself, but because many of the patients undergoing this procedure have severe systemic disease which make them poor risks for hysterectomy. Thus they have been referred to Sinai for the laser procedure. Cardiovascular disease from cardiomyopathy to coronary artery disease, coagulation disorders, and pulmonary disease are the most frequently seen disorders. Several of these patients have required pulmonary artery catheter insertion to monitor cardiac output and left ventricular function.

Control of upper GI bleeding with the laser infrequently involves the anesthesiologist, since the majority of the procedures are done in the endoscopy room. However, the severe cases are done in the operating room, usually starting with topical anesthesia and IV sedation. Protection of the airway from aspiration of blood can be very difficult with massive hemorrhage in the sedated patient, and occasionally the procedure is temporarily halted while the anesthesiologist places a cuffed oral endotracheal tube and the procedure is completed under general anesthesia.

We thus can see that cooperation between surgeon and anesthesiologist is particularly vital during the many types of laser procedures. Each must be aware of exactly what the other plans to do prior to the procedure in order to keep the incidence of complications at a minimum. Such planning has led to the safety of the numerous laser procedures performed at our hospital.

1984 Component society officers

ALLEGAN:

President:
M.A. Kaminski, MD, Otsego
Secretary:
Peter T. Savage, MD, 551 Line St.,
Allegan 49010

ALPENA—ALCONA—PRESQUE-ISLE

President:
R.J. Milligan, MD, Alpena
Secretary:
Peter Aliferis, MD, Alpena General
Hosp., Alpena 49707

BARRY

President:
E.E. Cassell, MD, Hastings
Secretary:
Paul T. DeWitt, MD, 1005 W. Green
St., Hastings 49058

BAY-ARENAC-IOSCO

President:
J.C. Cooper, MD, Bay City
Secretary:
A.C. Vasquez, MD, 200 S. Wenona
#225, Bay City 48706

BERRIEN

President:
F.H. Bunker, MD, Benton Harbor
Secretary:
Edwin G. Vann, MD, 4370
Tanglewood Trail, St. Joseph 49085

BRANCH

President:
Michael E. Gates, MD, Coldwater
Secretary:
J.C. Sennish, MD, 300 E. Chicago,
Coldwater 49036

CALHOUN

President:
P.R. Glotfelty, MD, Marshall
Secretary:
Mark H. Tucker, MD, 231 North Ave.,
Battle Creek 49017

CASS

President:
A.G. Lira, MD, Niles
Secretary:
Jashu N. Patel, MD, 515 Main St.,
Dowagiac 49047

CHIPPEWA-MACKINAC

President:
James W. Leete, MD, Sault Ste.
Marie
Secretary:
Eero Ranta, MD, 500 Osborn Blvd.,
Sault Ste. Marie 49783

CLINTON

President:
W.F. Stephenson, MD, St. Johns
Secretary:
Haresh B. Pandya, MD, 101
Northcrest Ctr., Lansing 48906

DELTA

President:
R.L. Hockstad, MD, Escanaba
Secretary:
Carl L. Olson, MD, 619 Minneapolis
Ave., Gladstone 49837

DICKINSON-IRON

President:
J.F. Selden, MD, Iron Mountain
Secretary:
D.M. Mitchell, MD, 106 W. "B" St.,
Iron Mountain 49801

EATON

President:
Eber Sherman, MD, Eaton Rapids
Secretary:
R.L. Leeser, MD, 210 N. Oliver,
Charlotte 48813

GENESEE

President:
E.H. Gullekson, MD, Flint
Secretary:
R.E. James, MD, G1071 N. Ballenger
Hwy. #309, Flint 48504

GOGEBIC

President:
Robert C. Lesher, MD, Ironwood
Secretary:
James M. Franck, MD, N12006 Bale
Lane, Ironwood 49938

GR. TRAVERSE-LEELANAU—BENZIE

President:
L.S. Loesel, MD, Traverse City
Secretary:
Gene D. Tang, MD, Munson Med.
Ctr. PTH, Traverse City 49684

GRATIOT

President:
R.N. Saxena, MD, Alma
Secretary:
Bruce E. Lee, MD, 820 N. Pine River,
Ithaca 48847

HILLSDALE

President:
Arthur J. Stein, MD, Hillsdale
Secretary:
Charles T. Vear, MD, 209 S. Howell,
Hillsdale 49242

HOUGHTON-BARAGA—KEEWEENAW

President:
Joseph F. Baron, MD, Laurium
Secretary:
D. Tepkasetkul, MD, 821 Water St.,
Hancock 49930

HURON

President:
Jun-Yih Jean, MD, Bad Axe
Secretary:
R.E. Lockard, MD, 40 N. Main St.,
Elkton 48731

INGHAM

President:
J. Clyde Spencer, MD, Lansing
Secretary:
Dawn E. Springer, MD, 230 Temple,
Mason 48854

IONIA—MONTCALM

President:
Marc G. Blass, MD, Ionia
Secretary:
L.E. Sanford, MD, 403 W. Main St.,
Belding 48809

ISABELLA-CLARE

President:
C.E. Allan, MD, Mt. Pleasant
Secretary:
V.B. Lebedovych, MD, 211 S. Crapo,
Mt. Pleasant 48858

JACKSON

President:
J.F. Stageman, MD, Jackson
Secretary:
L.E. Jennings, MD, 123 N. West Ave.,
Jackson 49201

KALAMAZOO

President:
James R. Dolan, MD, Kalamazoo
Secretary:
G.A. Wardwell, MD, 524 S. Park St.,
Kalamazoo 49006

KENT

President:
Bernard P. Kool, MD, Grand Rapids
Secretary:
Ivars Zadvinskis, MD, 1900 Wealthy
St., SE, Grand Rapids 49506

LAPEER

President:
K.S. Rajan, MD, Lapeer
Secretary:
Harry R. Zemmer, MD, 1065 N. Pine
St., Lapeer 48446

LENAWEE

President:
Steven C. Benz, MD, Adrian
Secretary:
T.O. Shanavas, MD, 770 Riverside
Ave., Adrian 49221

LIVINGSTON

President:
Dong S. Kim, MD, Howell

Secretary:
Helen C. Park, MD, 1325 Byron Rd., Howell 48843

LUCE

President:
Steven A. Myers, MD, Newberry
Secretary:
Robert D. Gibson, MD, 804 Newberry, Newberry 49868

MACOMB

President:
Ricardo Chalela, MD, Mt. Clemens
Secretary:
Richard A. Stone, MD, 198 S. Gratiot, Mt. Clemens 48043

MANISTEE

President:
R.L. Novack, MD, Manistee
Secretary:
David A. Wild, MD, 84 Cypress St., Manistee 49660

MARQUETTE-ALGER

President:
C.F. Hammerstrom, MD, Marquette
Secretary:
M.S. Grossman, MD, 829 Croix St., Negaunee 49866

MASON

President:
C.R. Pollard, MD, Ludington
Secretary:
Gerry L. Mayer, MD, 806 Russell St., Ludington 49431

MECOSTA-OSCEOLA-LAKE

President:
A.J. Foster, MD, Big Rapids
Secretary:
Frederick Guenther, MD, 415 Mecosta, Big Rapids 49307

MENOMINEE

President:
Edw. J. Pienkos, MD, Menominee
Secretary:
Wm. S. Jones, Jr., MD, 1146 10th Ave., Menominee 49858

MIDLAND

President:
Robert E. Roe, MD, Midland
Secretary:
J.H. Triebwasser, MD, 4922 Sturgeon Creek Pkwy., Midland 48640

MONROE

President:
J.C. Postigo, MD, Monroe
Secretary:
S.R. Nair, MD, 905 N. Macomb, Monroe 48161

MUSKEGON

President:
Erwin L. Grasman, MD, Muskegon
Secretary:
Craig L. Holmes, MD, 1675 Leahy St., Muskegon 49440

NEWAYGO

President:
E.S. Beckman, MD, Newaygo
Secretary:
Maynard DeKryger, MD, 230 W. Oak St., Fremont 49412

NORTH CENTRAL

President:
Tomlin C. Rosi, MD, Grayling
Secretary:
R.J. Potter, MD, P.O. Box 38 Hlth. Dept., West Branch 48661

NORTHERN MICHIGAN

President:
Robert T. Polack, MD, Petoskey
Secretary:
J.C. Shepard, MD, 560 W. Mitchell, Petoskey 49770

OAKLAND

President:
Gerald F. Conway, MD, Royal Oak
Secretary:
Michael Garcia, MD, 4400 Town Center #275, Southfield 48075

OCEANA

President:
V. Dale Barker, MD, Hart
Secretary:
V. Dale Barker, MD, 17 Courtland St., Hart 49420

ONTONAGON

President:
Steven N. Gervae, MD, Ontonagon
Secretary:
D.B. Pierpont, MD, 11-DP W. Jackson Rd., Ironwood 49938

OTTAWA

President:
J.E. Kellaway, MD, West Olive
Secretary:
Robert J. Bates, MD, 601 Michigan Ave. #201, Holland 49423

SAGINAW

President:
Fredk. J. Cady, MD, Saginaw
Secretary:
Jacob C. Ninan, MD, P.O. Box 2253, Saginaw 48605

ST. CLAIR

President:
Daniel J. Wilhelm, MD, Port Huron
Secretary:
John J. Zmiejko, MD, 1201 Stone St. #9, Port Huron 48060

ST. JOSEPH

President:
B.I. Mutnal, MD, Three Rivers
Secretary:
M.J. Kush, MD, 137 Portage, Three Rivers 49093

SANILAC

President:
Syed A. Ahmed, MD, Marlette
Secretary:
R.I. Cutcher, MD, 2433 Black River St., Deckerville 48427

SCHOOLCRAFT

President:
Jose Espinosa, MD, Manistique
Secretary:
Robert J. Urban, MD, 115 N. Lake St., Manistique 49854

SHIAWASSEE

President:
Robert P. Langen, MD, Owosso
Secretary:
Thomas M. Teal, MD, 148 N. Saginaw St., Chesaning 48616

TUSCOLA

President:
Maurice H. Chapin, MD, Millington
Secretary:
E.S. Sarabia, MD, P.O. Box 427, Mayville 48744

VAN BUREN

President:
David J. Millard, MD, Paw Paw
Secretary:
Edward W. Lean, MD, 305 E. Oak St., Paw Paw 49079

WASHTENAW

President:
Robert J. Fisher, MD, Ypsilanti
Secretary:
P.M. Margolis, MD, 900 Wall St., Ann Arbor, 48109

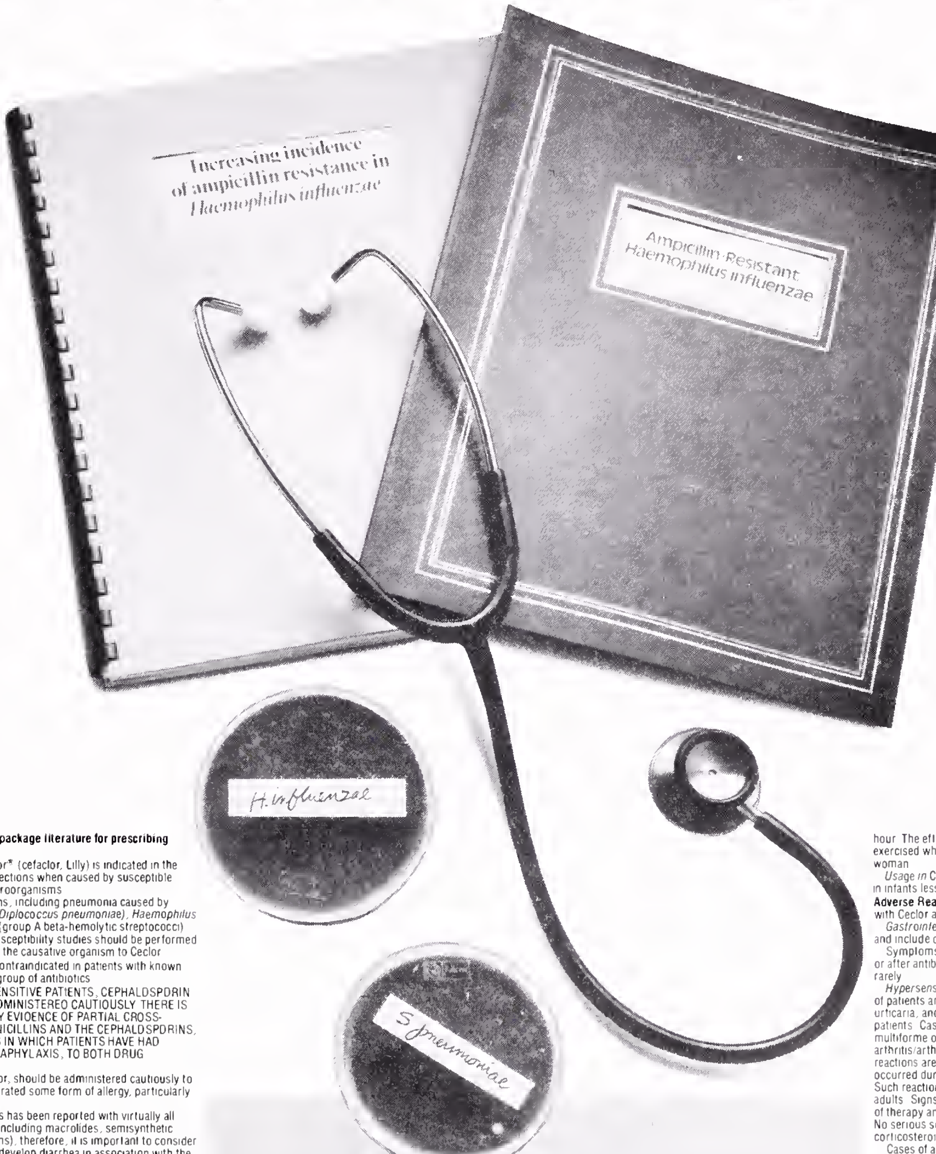
WAYNE

President:
Susan E. Adelman, MD, Detroit
Secretary:
W. Peter McCabe, MD, 20361 Mack Ave., Grosse Pte. Woods 48236

WEXFORD-MISSAUKEE

President:
R.H. Lamkin, MD, Cadillac
Secretary:
John F. Itnyre, MD, 520 Cobb St., Cadillac 49601

An added complication... in the treatment of bacterial bronchitis*



Increasing incidence of ampicillin resistance in *Haemophilus influenzae*
Ampicillin-Resistant Haemophilus influenzae
H. influenzae
S. pneumoniae

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by C. *difficile* Other causes of colitis should be ruled out

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e g , pressor amines, antihistamines, or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs´ tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs´ testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs´ test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict´s and Fehling´s solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers—Small amounts of Ceclor have been detected in mother´s milk following administration of single 500-mg doses Average levels were 0 18, 0.20, 0 21, and 0.16 mcg/ml at two, three, four, and five hours respectively Trace amounts were detected at one hour The effect on nursing infants is not known Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1 5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs´ tests each occur in less than 1 in 200 patients Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor Such reactions have been reported more frequently in children than in adults Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic—Slight elevations of SGDT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200)

[061782R]

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

---

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S pneumoniae* or *H influenzae* [8]

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information

References
1 Antimicrob Agents Chemother , *8* 91, 1975
2 Antimicrob Agents Chemother., *11* 470, 1977
3 Antimicrob Agents Chemother , *13* 584, 1978
4 Antimicrob Agents Chemother , *12* 490, 1977
5 Current Chemotherapy (edited by W Siegenthaler and R Luthy), II 880 Washington, D C., American Society for Microbiology, 1978
6 Antimicrob Agents Chemother., *13* 861, 1978
7 Data on file, Eli Lilly and Company
8 Principles and Practice of Infectious Diseases (edited by G L Mandell, R.G Douglas, Jr , and J E Bennett), p 487 New York John Wiley & Sons, 1979

© 1982, ELI LILLY AND COMPANY

Lilly

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

300035

By F. Charles Peller

DSS studying variety of health care delivery systems

The major benefit of Medicaid financing is to increase access to health care for the low-income population resulting in improved health. However, it also has increased "doctor shopping" and excessive uses of emergency rooms.

Medicaid recipients have free use of a card which guarantees unlimited health care, thereby causing indifference to medical costs incurred on their behalf.

Simultaneously, there is a small percentage of the provider population whose costs far exceed the averages and apparently cannot be explained by the case mix of their patients.

These skyrocketing costs are causing a squeeze on the state budget, a problem heightened by the balanced budget regulations. This has led to reductions and curtailment of state services in many areas. The Department of Social Services has experienced cutbacks in the levels of assistance grants and staff.

These multiple problems have resulted in the introduction of several health care delivery systems designed to reduce the rates of utilization and costs of health care services. The Department of Social Services has received a grant from the Health Care Financing Administration of the Department of Health and Human Services to study these alternative methods.

Alternative delivery systems

Our study will review four payment alternatives which involve varying degrees of "risk sharing" by providers. The goal is to identify ways to continue administering quality health care to Medicaid recipients while trimming inappropriate utilization and costs.

The four delivery systems to be studied represent the spectrum of risk sharing alternatives. They are:

1. The Physician Primary Sponsor Plan (PPSP); a project which involves primary care physicians as case managers.
2. Capitated Ambulatory Plans (CAPs); a case management approach similar to HMOs, excluding responsibility for payment of inpatient hospitalization.
3. Health Maintenance Organizations (HMOs); at the opposite end of the risk sharing spectrum from fee-for-service.
4. The traditional fee-for-service (FFS) payment method.

Project objectives

The major objective of the study is to determine the effect of the various health care delivery systems on:

1. Physician utilization and cost patterns;
2. Medicaid recipient utilization patterns;
3. Medicaid recipient health care satisfaction;
4. Physician satisfaction.

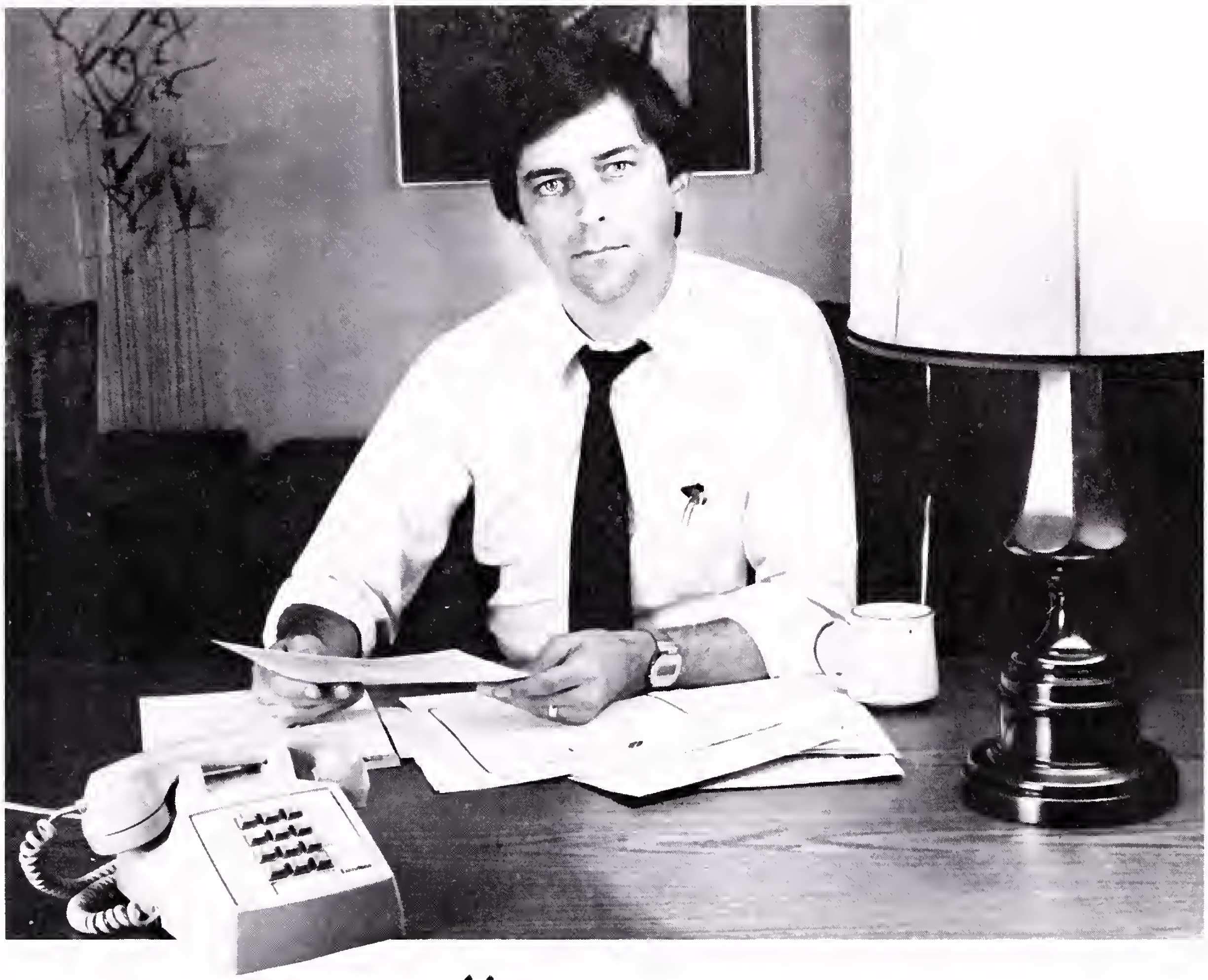
Data collection

The data to be collected will be directly related to these objectives. We will gather utilization and cost data mainly from existing Department of Social Services information systems. Supplemental information not available from that system will be supplied by the HMOs and the CAPs.

Medicaid recipient and physician satisfaction information will be gathered by surveys administered on a before and after basis. The DSS completed the first recipient survey in the fall of 1983. We expect preliminary analysis this summer. The physician survey is being conducted by Theodore Goldberg, MD, professor and chairman, Community Medicine, Wayne State University.

The Evaluation Division of the Michigan Department of Social Services will conduct this three-year study. The findings ultimately could lead to changes in federal law or regulations governing Medicaid reimbursement and procedures.

Mr. Peller is now a senior departmental analyst with the Evaluation Division, Michigan Department of Social Services.



"...Your financial security specialist is on call"

American Physicians Life believes a physician's financial security deserves specialized attention. That's why our products and services are designed with the doctor in mind. Our comprehensive portfolio of services, including life insurance, professional disability income coverage, qualified plans and tax-deferred annuities, is customized to meet your personal financial planning needs as well as those of your professional corporation.

Let American Physicians Life secure your financial planning program—that's our specialty!

Call today for the financial security specialist in your area.

AMERICAN PHYSICIANS LIFE
Bates Drive, P.O. Box 281
Pickerington, Ohio 43147
Telephone (614) 864-3900
Toll-free in Ohio, 1-800-282-7515
Toll-free outside Ohio, 1-800-742-1275

By Carl F. Hammerstrom, MD

Citizens must decide how much appropriate for health care

Doctor Hammerstrom

The following is reprinted, with permission, from a letter printed in the Marquette Mining Journal. The writer is a new district director for MSMS.

The public should understand that the rising cost of medical care cannot be attributed merely to physician fees. Less than 20 percent of the cost of medical care is attributable to physician fees. While the total amount of dollars which Medicare and Medicaid pays for physician services has increased, much of this is due to the increasing numbers of our population eligible for Medicare and Medicaid and the increased demand that an educated population has made to receive the best that is available in medical care. Regularly the lead article from the New England Journal of Medicine is reported on the front page of your paper before I receive the magazine in the mail.

While the Medicaid population is proportional to the state of the economy, the number of aged citizens in our population is increasing. The 65 and older age group eligible for Medicare will grow by an additional 31 percent between now and the year 2000 and is expected to accelerate in the next century as the "baby boom" generation reaches retirement age.

The physicians of America have demonstrated a remarkable ability to make the state of the art of medical care available to their patients, and I believe the position of the American Medical Association as stated in their March 7, 1984 letter demonstrated again our responsible attitude toward making the cost of a physician's services as reasonable as possible. We do not believe that "price controls" for services will significantly alter the cost of medical care, and fear that prospectively fixing the price which the government will pay for the care of a specific illness (the diagnosis related grouping experiment "DRG") is likely to limit access to care for our patients.

A plan must be developed to attempt to control the expense of medical care; but first the citizens of our land must make decisions as to how much is appropriate to be spent for medical care and then to set priorities for how those dollars should be spent. It is not appropriate to expect personal physicians to merely ration the care that is available to their patients.

In addition, the citizens of our nation must recognize their individual responsibilities to minimize health care costs by appropriate personal health measures. It seems ludicrous to ration the care available to our elderly while the public is allowed to drive autos without wearing seat belts, when the major causes of disability, heart and lung disease, are known to be due to smoking, and health insurers are not encouraged to promote health by reimbursing patients for appropriate outpatient screening techniques or education about the preventative advantages to be gained by proper health habits.

Doctor Hammerstrom is president, Marquette-Alger County Medical Society.

Let our trust experts write the prescription for your retirement plan.

Handling your own retirement plan can be strong medicine. You can get caught up in paperwork and record keeping, end up spending more time than you'd like to, and then wonder if you've made the right decisions.

There is a way to a healthier, trouble-free retirement plan: Let the trust experts at Comerica Bank prescribe the proper management.

It's very simple. You concentrate on what you do best, and let us concentrate our expertise on your retirement plan.

This doesn't mean you can't get involved. We're very flexible. We'll do just about as much or as little as you want us to.

To make sure that your account is handled smoothly and efficiently, we assign a specific Employee Benefit officer to your account. Any time you have questions, or want to know how things are going, just call him.

Think it over. We can take a big load off your back and off your mind.

Call Terrence E. Keating at (313) 222-3898, or write to him at Comerica Bank-Detroit, P.O. Box 59, Detroit, MI 48232.

Let us know when we can start. After all, you're the doctor.

Comerica
BANK

How to offer arbitration to patients

This article was written to inform physicians about the requirements of the medical malpractice arbitration program. It describes the similarities and differences between arbitration and the courts as a means of settling malpractice suits. It also tells what you as a physician must do if you want to offer the arbitration option to your patients.

Background

In 1975, two laws were passed in Michigan in response to the medical malpractice insurance crisis which allow patients to choose arbitration, rather than going to court, as a means of settling malpractice disputes. Non self-insured hospitals, clinics, health maintenance organizations and sanitariums are required to offer the arbitration option to each patient admitted or treated. Other health care providers, including physicians, have the option of offering patients the choice of arbitration in their offices.

An arbitration agreement signed in a hospital by an inpatient, or a patient receiving outpatient surgery, or a patient treated in the emergency room, covers treatment received during that particular hospital admission or visit. An arbitration agreement signed in a hospital outpatient clinic covers a full year of treatment in the clinic. An arbitration agreement signed by a patient in a physician's office covers one year of treatment by the physician and applies only to claims or disputes arising out of medical care received in the office.

What is arbitration?

Arbitration is a substitute for the court-jury system. A three-person panel of arbitrators, rather than a judge or jury, hears and makes a final decision about a dispute arising out of health care treatment. One member of the arbitration panel is a lawyer, one is a physician or other health professional, and one is a representative of the general public.

Some physicians mistakenly believe that arbitration is a compromise process in which everybody gets something. Arbitration is a legal proceeding similar to court; the plaintiff must **prove** his or her case. In the eight years that arbitration has been available, 76 percent of the cases were settled or withdrawn before reaching an arbitration panel. Of the cases decided by an arbitration panel, the ratio of awards to dismissals has been similar to the ratio in the court system.

Going to court and arbitration — how are they alike?

Both the patient and the physician:

- Have a chance to present their case to a group of people who will decide the matter.
- Take part in choosing the people who will decide the case.
- Have the right to question the witnesses for the other side.
- Have a right to a lawyer.
- Have a right to a fair hearing protected by law.

What does the law require of providers?

By law, providers must use only standardized arbitration agreement forms and Patient Information Booklets approved by the commissioner of insurance in making the offer of arbitration to patients. A Patient Information Booklet must be given to each patient to whom arbitration is offered. The patient must always be given a choice of whether or

---

This article was prepared by the Medical Arbitration Program, Insurance Bureau, Department of Licensing and Regulation, Lansing.

Going to court and arbitration — how are they different?	**Court**	**Arbitration**
Who hears the case?	Judge and jury. A jury is a panel made of up six members of the public.	Panel of three people: a lawyer, a doctor or a hospital administrator or other provider, and a member of the public.
How soon will my case be heard?	It may be as soon as both sides are ready. But it may take several years, especially in large cities where courts are crowded.	As soon as both sides are ready. Usually less than a year.
Will the trial be open to the public?	Yes.	No.
If the patient wins, what results are possible?	Structured or periodic payments, rehabilitation services, or a combination of these.	Structured or periodic payments, rehabilitation services, or a combination of these.
Can either side appeal the decision?	Yes, the patient or the physican can appeal to a higher court for a review of the first decision.	The panel's decision is usually final.

not to sign an arbitration agreement. **Providers may not make signing an arbitration agreement a prerequisite to health care.**

Offering arbitration to patients in your office

1. Let each patient freely choose whether or not to sign the arbitration agreement, which covers one year of treatment in the office.
2. Use Form IBA 100, approved by the commissioner of insurance.
3. Present the Patient Information Booklet when you make the offer. Use the version of the booklet designed for hospital outpatients, HMOs and physicians' offices (IBA 300B). The law requires that the booklet be provided when the arbitration offer is made. Failure to provide the booklet could invalidate a signed arbitration agreement.
4. Make sure agreements are signed by you (or your representative) and the patient. The patient should receive a copy of the signed arbitration agreement.
5. Inform your staff about these requirements of the law.

Some physicians believe that informing patients about arbitration will lead to an increase in "nuisance" malpractice claims. During the eight years that hospital patients have been advised of arbitration, there is no evidence that more malpractice claims have been generated as a result.

Making arbitration available to patients you treat in a hospital:

1. Sign the Independent Health Care Provider and Hospital Agreement which the hospital will offer you. Then, if your patient signs an arbitration agreement with the hospital, you will be covered in the event the patient makes a claim. The hospital agreement covers treatment rendered during a single hospital stay or emergency room visit. A new agreement must be signed each time the patient visits the hospital (except that agreements signed in an outpatient clinic cover a year of treatment).
2. Allow the hospital staff to offer the arbitration agreement to your patients. This agreement covers treatment in the hospital. Please note that one of the major concerns of the program is the offer of arbitration in the hospital. If you have any concerns about the hospital offer, discuss them with the administrator.

All physicians who offer arbitration in their offices are urged to sign the Independent Health Care Provider and Hospital Agreement in hospitals with which they are affiliated. If a dispute should arise out of health care or treatment provided while your patient is hospitalized, an agreement signed by the patient in your office will not cover that dispute.

Physicians who are paid employees of a hospital are automatically covered by the arbitration agreement offered to all hospital patients.

For more information

Physicians are encouraged to contact the Bureau concerning questions, complaints, or comments regarding the arbitration program.

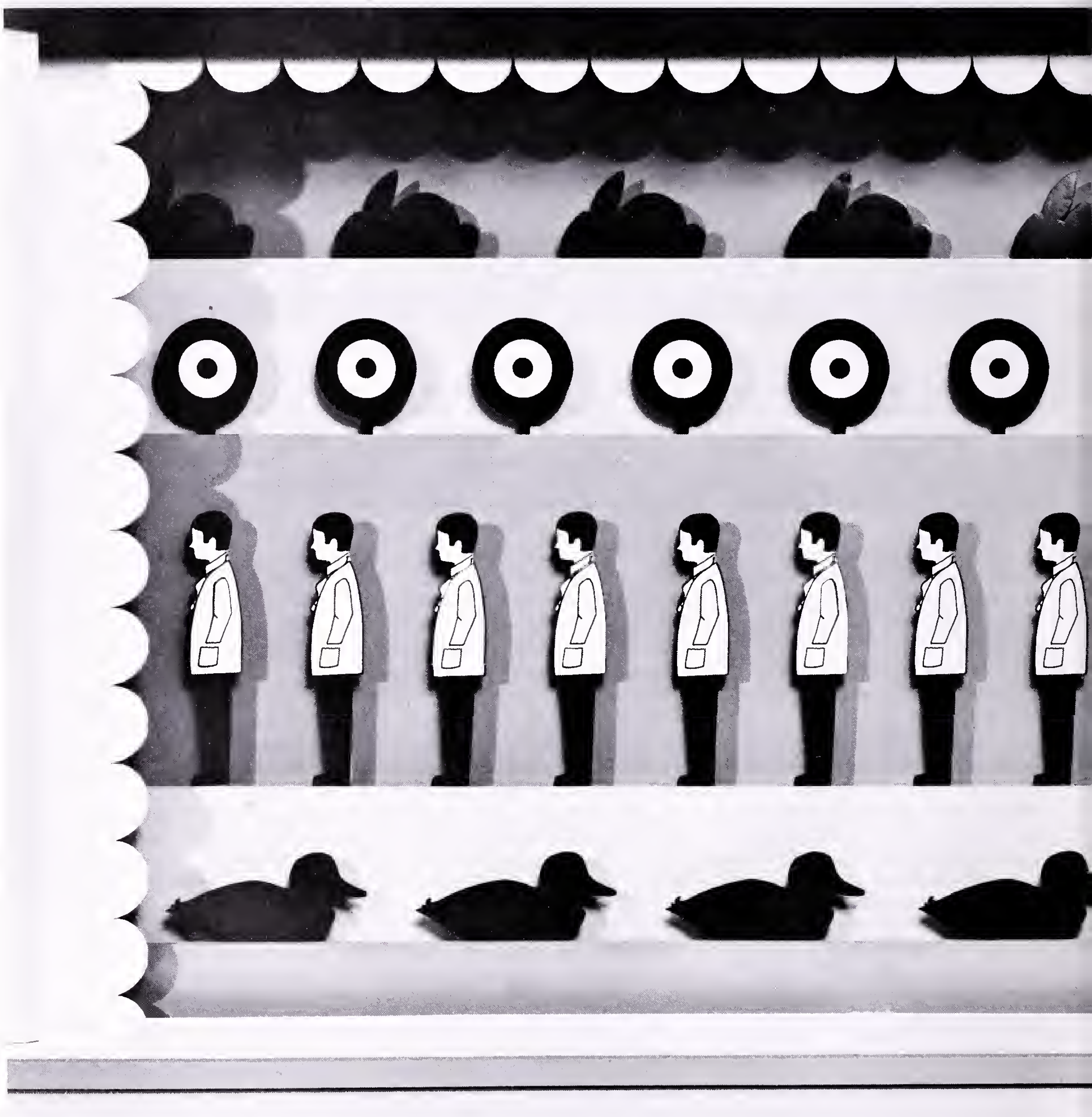
If you have any questions or would like a sample copy of an agreement or Patient Information Booklet, you may write to:

Medical Arbitration Program
Michigan Insurance Bureau
P.O. Box 30220
Lansing, MI 48909
or phone (517) 373-2984.

If you want more information about becoming a panel member for arbitration hearings, please contact:

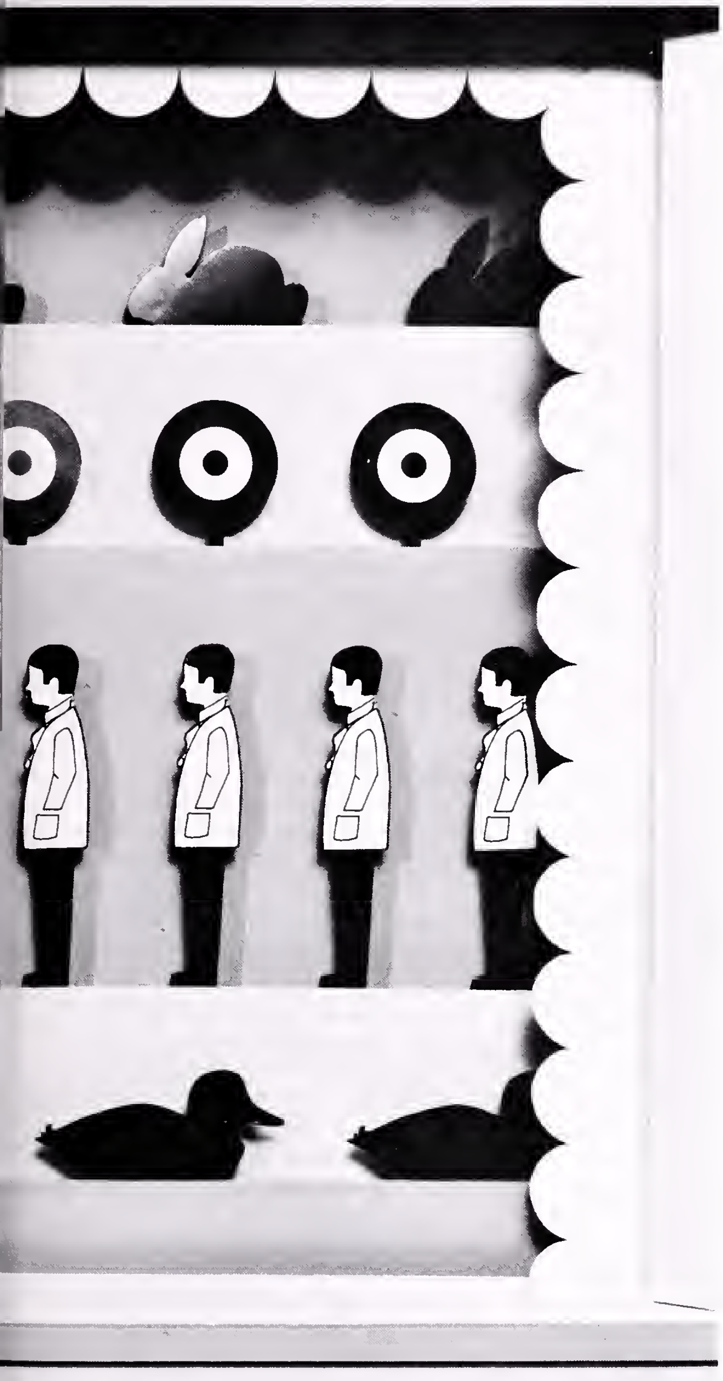
William Madigan, Deputy Director
Michigan State Medical Society
120 W. Saginaw St.
East Lansing, MI 48823

If you become the target of a



©1983 MPMLC

professional liability claim...



You will be glad you have Michigan Physicians.

Michigan Physicians has been solving complex medical professional liability problems since 1976. With the state's largest and most experienced claims staff, Michigan Physicians works with you to resolve claims (and incidents) that most physicians have never faced in their careers.

In a changing legal environment, you need the best coverage you can buy because the risk of a professional liability claim is becoming greater every day.

For a confidential rate quotation and more information about Michigan's leading physician-owned insurance company, call or write the office in your area.

Michigan Physicians
Mutual Liability Company

1305 Abbott Road
East Lansing, MI 48823
(517) 351-1150
(800) 292-1926

6735 Telegraph Road
Suite 205
Birmingham, MI 48010
(313) 647-5550

Endorsed by the Michigan State Medical Society

Heart transplant

Physicians at The University of Michigan Hospitals performed a heart transplant operation on a 39-year-old man May 1. This was the first human heart transplant in Michigan since 1975. Prior to 1975 seven heart transplant operations were performed at the U-M.

The body of the donor, a 17-year-old youth whose brain no longer functioned after a gunshot wound to the head, was driven to Ann Arbor from Marquette by ambulance. (High winds prevented utilizing air transport.) The heart was kept beating by means of drugs and a respirator.

In announcing the surgery, Jeremiah G. Turcotte, MD, chairman of the Department of Surgery, said the status of the patient, who has requested anonymity, was "satisfactory considering the seriousness of the surgery."

The principal surgeons for the approximately 2½ hour operation were Douglas W. Behrendt, MD; Marvin M. Kirsh, MD; and Richard W. Long, MD, thoracic surgeons on the U-M Hospitals (UMH) recently formed multi-organ transplant team headed by Doctor Turcotte. The team will perform kidney, pancreas, liver and heart transplants, Doctor Turcotte said.

The U-M has resumed performing heart transplants after almost 10 years, Dr. Behrendt said, because the results of such surgery have improved greatly in the last few years.

LUNGNET

The American Lung Association of Michigan (ALAM) has established a network call LUNGNET to fight for better respiratory health.

LUNGNET is available free to citizens and organizations in Michigan. It focuses on smoking or health, occupational health and air pollution and toxicant control.

LUNGNET serves concerned citizens by providing timely and pertinent information so citizens can influence governmental affairs and legislation affecting respiratory health.

For further information on how you can become registered on the LUNGNET mailing list, write ALAM, 403 Seymour Avenue, Lansing, 48914, or call tollfree at 1-800-292-5979. In the Greater Lansing area, call (517) 484-4541.

Tampon labels

A University of Michigan professor of nursing has found that tampon labeling poses a stumbling block for women who wish to avoid high absorbency tampons because of the risk of toxic shock.

In 1982, the Institute of Medicine advised adolescent women and mothers within six to eight weeks after delivery to avoid high absorbency tampons in order to lessen their chances of getting the rare infection.

However, Nancy F. Reame, PhD, associate professor of nursing, says, "Current tampon labeling makes this recommendation meaningless."

Prof. Reame's study found that absorbency rates of tampons with the same size designations — junior, regular, super, super-plus — vary widely, confirming similar studies.

Because current labeling is insufficient for comparing absorbency across brands, women who wish to avoid high absorbency brands because of risk of toxic shock will find it very difficult to do so.

The incidence of toxic shock today is 35 cases a month, down from the peak month of 135 cases in August 1980. According to the latest figures available from the Centers for Disease Control (CDC) in Atlanta, 2,401 cases have been confirmed, including 108 deaths.

Reye's Syndrome

The Michigan Department of Public Health Reye's Syndrome Winter Summary reports 20 cases of Reye's Syndrome in Michigan with onset from October 1, 1983 to April 30, 1984. Three of those afflicted died. During the same period in 1982-1983 there were 11 cases with one death, in 1981-1982 there were 21 cases with seven deaths, and in 1980-1981 there were 18 cases and no deaths.

The age of this year's cases ranged from eight months to 25 years, with a median of six years. Six cases occurred in children less than five years old. Eleven cases were male and all were white.

The cases were from 16 different counties and only Genesee (four) and Wayne (two) reported more than one. Michigan ranked second in the Great Lakes Region behind Ohio for the number of cases in this period. Ohio had 27 cases and the third ranking states were Wisconsin and Minnesota with eight each. A total of 73 cases were reported for this period in the region.

Cases of Reye's Syndrome peaked between February 3 and 17. This peak correlated well with the peak in reported influenza-like illness and the peak in the number of school closings because of influenza-like illness.

Again this year both type A (H1N1) and type B influenza viruses circulated. Type B influenza viruses predominated in the late winter-early spring period.

Chart review for the 20 reported cases in Michigan children will be done next fall. Note that the data included in this summary was based only on the initial hospital admission data and is therefore preliminary.

Those who would like to have summary data not presented in this update should contact William Hall, MD, or Harry McGee, MPH, by phone (517) 373-1396 or letter.

Hospitals merge

The Huron Valley Hospital soon to be built in western Oakland County has signed a letter of intent to merge with Harper-Grace Hospitals.

Harper-Grace operates Harper

Hospital in the Detroit Medical Center and Grace Hospital in northwest Detroit. Last December it announced plans to consolidate with Hutzel Hospital, which also is located in the Detroit Medical Center. In addition, Harper-Grace Hospitals has filed for a certificate of need for a 225-bed hospital to be built at Haggerty Road and Pontiac Trail in western Oakland County.

The entity which will be formed as a result of the agreements with Huron Valley and Hutzel will make the new system the largest health care provider in Michigan. It will include hospitals with about 2,000 beds and have interests in a variety of other health care organizations including home health care providers, medical office buildings and clinics, nursing homes, and medical equipment suppliers.

Huron Valley Hospital initially will have 153 beds and has filed an application with the state of Michigan for an additional 150 beds. Under the arrangement with Harper-Grace, Huron Valley will be a general hospital serving western Oakland County.

While it will have its own medical staff, it will secure the services of specialist doctors from Harper, Grace and Hutzel hospitals. To contain costs and avoid duplicating services it will be able to transfer patients easily by ambulance or helicopter to Harper and Hutzel for treatment that is available only in large academic medical centers.

Trauma victims

The first residential treatment program for victims of trauma deliberately inflicted by another human being is in operation in the rural Lansing area.

It is the Victim Assistance Program of the Stress Reduction Center of Lansing's St. Lawrence Hospital. Designed to enhance physical and psychological recovery, it also is to reduce the risk of expensive, debilitating social and psychological maladjustment.

It is a short term (seven to 21 days) intensive therapeutic treatment experience for adult men and women who have suffered a traumatic victimization episode, and who are unable to resolve this crisis alone. The program's therapeutic approach consists of four basic elements: fitness, education, therapy and social integration.

The multi-disciplinary staff includes a primary care physician on call. Medical director is Frank M. Ochberg, MD, former director of the Michigan Department of Mental Health.

AMRC

Advance Medical & Research Center, Inc., Pontiac, has been awarded a two-year accreditation by the Commission on Laboratory Accreditation of the College of American Pathologists (CAP), based on results of a recent on-site inspection.

LABORATORY OF CLINICAL MEDICINE
MID-MICHIGAN REFERENCE LABORATORY, II, Inc.
(517) 372-8180

1322 E. Michigan Ave.
Suite 211
Lansing, Michigan 48912

930 E. Mt. Hope Ave.
Lansing, Michigan 48910

2909 E. Grand River Ave.
Suite 104
Lansing, Michigan 48912

W. E. Maldonado, M.D.
Director

Robert B. Foy, Ph.D.
Chief Executive Officer

Ann E. Chernys, M.D.
John W. Dyke, Ph.D.
Dennis E. Freer, Ph.D.
John J. Gillespie, M.D.
Ronald N. Horowitz, M.D.
John R. Kateley, Ph.D.

John J. Lyday, M.D.
Joseph R. Melvin, Ph.D.
Sandra K. Shirley, M.D.
Laurence R. Simson, Jr., M.D.
Susan M. Strate, M.D.
Irene K. Trombley, M.D.

REFERENCE LABORATORY FOR SPECIALIZED PROCEDURES
Specimen Pickup and Delivery of Test Results Daily
House calls are available upon Physician's request
Assignment is accepted from Medicare, Medicaid, Blue Shield and all other insurance carriers.

The AMA is calling on physicians to become leaders in eliminating child abuse. To inaugurate its efforts to help physicians lead, the AMA staged its first national conference on child abuse and neglect March 30-31 in Chicago. Experts offered suggestions on how physicians may take action. Chairman of the conference was Douglas Sargent, MD, Grosse Pointe Farms psychiatrist.

Keynote speaker Ray E. Helfer, MD, East Lansing pediatrician, related his 25-year history of pioneering efforts to identify and eradicate child abuse. He also was honored as recipient of the first AMA citation for outstanding contributions and dedicated service to the field.

AMA holds first national child abuse conference

Breakout sessions (one featured Doctor Helfer as leader) took up such topics as prevention strategies, vulnerable families, volunteers' role, legal perspectives, legislative initiatives, and sexual abuse. One series provided the chance for several states, including Michigan, to describe efforts underway at home.

Photos courtesy Joe Fletcher of the AMA.

Who needs over a million dollars in professional liability protection?

Very Possibly YOU Do!

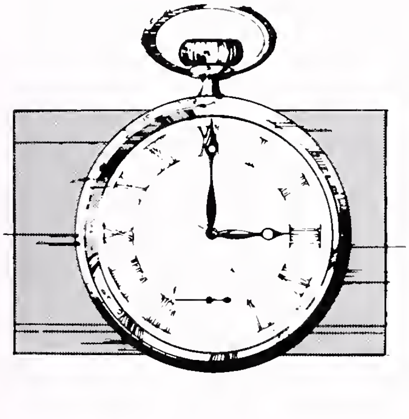
The Michigan lawyers' MILLION DOLLAR CLUB is comprised of attorneys who have won awards over that amount, many from physicians or surgeons who had exercised their very best judgement.

And the jury awards continue to grow.

The Michigan Doctor's Excess Professional Liability Insurance affords...

Protection That Starts When Your Present Policy Stops — And The Jury Keeps Going.

It does not replace your present policy, but it surely supplements it — up to $3 million additional limits.



Now Is The Time To Act!

Changes are effective right now that could be very beneficial to you and your practice. Such as:

- The availability of limits of liability up to **$3,000,000/$3,000,000** excess of $200,000/$600,000 or excess of $1,000,000/$1,000,000;
- A **rate reduction of 10%** for all classes purchasing limits in excess of $200,000/$600,000;
- For P.C.'s, clinics, etc., **discounts up to 50%** for relief or substitute physicians;
- **40-30-30 payment plan** available for annual premiums of $5,000 and above.

For further details about Michigan Doctor's Excess Professional Liability Insurance, please contact HASCO or your insurance agent.

Underwritten by: **PACIFIC EMPLOYERS INSURANCE COMPANY**
Los Angeles, California

Serviced by:
HASCO
P.O. Box 33008
Detroit, Michigan 48232
(313) 567-1955

MSMS testifies for malpractice bill

Following is the MSMS position regarding proposed medical malpractice legislation. MSMS State Legislation and Regulations Committee Chairman Frederick V. Minkow, MD, Pontiac, provided reasons why the bill is needed, when he testified at the April 12 public hearing of the Senate Judiciary Committee.

The MSMS-sponsored omnibus malpractice bill, designed to ward off another medical malpractice insurance crisis threatening the state, has lain dormant since it was introduced over a year ago.

Introducer Sen. Patrick McCollough (D-Dearborn) sought agreement between the State Bar and MSMS over the terms of the proposed legislation following its introduction. He was reluctant to move the bill forward without the two groups' mutuality. Legislators then would not take up the controversial bill when they became gripped with "recall fever."

Finally, this spring, the Senate Judiciary Committee held its first public hearing. Both the State Bar and MSMS testified. Following their testimony a special subcommittee was formed to study the issue further. On the subcommittee are Sens. Basil Brown, Richard Fessler (chairman), and Rudy Nichols.

As you will recall, there was a "medical malpractice crisis" in 1974 and 1975 when Michigan was faced with the potential loss of medical practitioners, since doctors could not obtain professional liability insurance. A series of legislative measures, including the establishment of a state-operated insurance fund and an arbitration program were enacted.

A new but different malpractice crisis is facing us that is much more menacing and far more serious than the unavailability of insurance. The number and size of malpractice claims is growing beyond reasonable bounds.

Let me present the dimensions of today's situation. The annual number of malpractice claims against Michigan physicians has risen from 218 in 1977 to 1,120 in 1981. That is more than a 500 percent increase. It is estimated that the figure for 1982 will show nearly 1,500 claims. In 1977, that meant 5.3 doctors of every 100 experienced a malpractice action filed against them; in 1982 the figure was 23.3 of every 100 insured doctors — four times as many.

While malpractice suits are being instigated at an alarming rate, Michigan physicians through the state medical society have initiated and participated in a number of programs designed to strive for the highest standards of medical and surgical practice. Michgian State Medical Society maintains its commitment to foster and support continuing medical education. Since 1975 state law (PA 112) requires all physicians to take 150 hours of continuing education courses over a three year period. Michigan State Medical Society is also highly supportive of the efforts of Elizabeth R. Howe, director of the Department of Licensing Regulation, to strengthen the licensure and disciplinary functions of the Michigan Board of Medicine. Unfortunately, there appears to be an inverse relationship between the efforts to improve the quality of medical practice and the number of lawsuits against physicians. While the sophistication and technical expertise of medicine reaches an all-time high, the threat of malpractice litigation keeps growing.

MSMS seeks legislative action on SB 224, introduced by Senator Patrick McCollough, to meet this explosive rise in medical malpractice judgments. Michigan doctors and hospitals face the highest risk for potential liability in our state's history — and consequently, the highest liability insurance rates. That cost is borne by each patient needing the services of a physician or hospital. Health care costs are rising and the litigation problem is one of the fundamental causes.

Organized medicine in Michigan strongly supports the measures in SB 224, because it corrects five inequities in the system. As a representative of physicians today, I must state that physicians believe this bill will have the effect of immediately lowering their malpractice premiums. Michigan Physicians Mutual Liability Company has indicated that placing a limit on pain and suffering awards alone would result in a substantial drop in premiums. This bill also would have a stabilizing effect in slowing down the rapid rise in both numbers of cases filed and the size of awards. It won't be long before Michigan catches up with states such as New York, where the average cost of a closed claim is $357,000; or California, where 47 percent of awards exceed a quarter of a million dollars.

The New York Malpractice Insurance Association which insures 1,600 physicians is now facing a $50 million deficit. The Florida Patients' Compensation Fund set up in 1975 by their legislature fell apart last year. The fund has no members today and $122 million in unpaid claims.

These financial dilemmas are in part due to record-breaking awards. For example, in Brooklyn, New York a baby girl was awarded $29.2 million for complications following meningitis. In Stanford, California an infant became spastic and paralyzed after suffering respiratory failure. Out of court settlements provide for annual payments that could exceed $120 million if she lives to age 78.

Michigan also is seeing an explosion in the number of awards in excess of a million dollars for children suffering the effects of birth trauma. Thus, the crisis in the bellweather states of New York, Florida, and California should be a clear warning for Michigan.

Before it's too late, legislation must be enacted. Specifically Senate Bill 224 covers these five points:

1. **Elimination of the Collateral Source Rule.** Under present court rule, a jury cannot be told of the existence of other kinds, forms or amounts of payment of existing insurance resources payable to an individual seeking a malpractice judgment against a physician or hospital. This legislation would require full disclosure of all compensation or payments received by the plaintiff from other sources as a result of a professional liability incident. Other states have passed this collateral source rule. According to a Rand Corporation study, relaxing the ban on evidence of collateral sources of compensation for injuries appeared to reduce trial awards by 18 percent.

2. **Assures the quality of expert testimony.** This portion of the bill would set forth in clear terms the criteria necessary to be an expert witness in a professional liability trial. The language says that an "expert" witness shall have a Michigan medical or osteopathic license and devote three-fourths of his or her time to the practice or teaching of that specialty. This requirement would eliminate the professional witness who may do nothing but travel the country giving testimony in medical malpractice cases without ever truly practicing medicine.

3. **Abolition of joint liability.** Presently, any defendant in a multiple defendant case is required to pay the entire amount of judgment to the plaintiff upon demand regardless of his or her share of responsibility, if any, for the act in question. In other words, though I may be responsible for only five percent of the plaintiff's injury, I could be ordered to pay for the entire award if the other parties in the case had no professional liability insurance. Proposed legislation would require a determination of degree of fault wherein a defendant (hospital, physician, nurse and others) would be responsible only for that amount attributable to his/her relative degree of fault.

4. The fourth area addressed by this legislation concerns itself with placing a **limit on non-economic damages.** It is the right of an injured party in a malpractice judgment to recover the full amount of actual economic loss of earning and earning capacity, medical and hospital expense in the past and reasonably predictable in the future. Today we are faced with the problem wherein a substantial portion of verdicts being rendered in medical malpractice cases are not for economic loss, but rather for intangible and ambiguous items such as pain and suffering, inability to lead a normal life, and so on. These claims of loss defy accurate or even approximate monetary assessment. Therefore, this bill proposes that while there may be room for some recovery of non-economic losses in no case shall the amount of damages for non-economic loss exceed $500,000. If we can eliminate some of these high payouts for non-economic losses I believe we can do a great deal to bring about a leveling out of the rapidly escalating insurance premiums.

5. Another major item addressed by SB 224 is that which would provide **periodic payments of damages beyond those monies needed to cover immediate expenses.** One of the contributing factors to the high professional liability insurance premiums is the common practice of awarding millions of dollars for future care and treatment and living costs based on an assumption of 30 more years of life expectancy and projected inflation factors. Yet the patient might only live 10 years before dying of some other cause entirely unrelated to the injury for which compensation is received. These awards are not intended to provide a windfall inheritance to the patient's survivors. The structured payout offers protection to the injured person by preventing injudicious use of lump sum settlements by guardians or persons ill-equipped to handle large sums of money. Such lump-sum settlements have been exhausted before all the needs of the injured person have been met. This legislation would provide for periodic payments of damages at the request of either party in awards exceeding $50,000 in future damages.

The legislation also provides that money damages awarded for loss of future earnings shall not be reduced or terminated by reason of the death of the plaintiff to whom the judgment is owed, but shall be paid to the legal survivors or heirs who were dependent upon the plaintiff for support.

In summary, it has been estimated that nationwide, $15 billion per year is wasted on defensive medicine. That cost, plus the outlay of $3.5 billion for liability protection for American physicians, their employees, and hospitals represent a significant but unnecessary national expenditure.

I think the medical community and the citizens of Michigan face a new and more ominous malpractice crisis. While no one is suggesting that those persons who are injured as a direct result of a physician's negligence should not be compensated, we are suggesting that there are mechanisms which would exert a greater degree of control on the system.

It is our earnest hope that by successfully passing this legislation, Michigan can stem the tide of increased numbers of malpractice suits and sky-high awards. This would bring a new stability to the insurance rate-setting process, thus enabling Michigan hospitals and doctors to afford their professional liability premiums while at the same time assuring fair treatment of the injured party.

State actively working to revamp Board of Medicine

The body that licenses and disciplines physicians in Michigan — the Board of Medicine — has come under heavy fire in recent years. Among those taking aim at problems they perceive with the board's functioning have been individual physicians, other state government agencies, the public and MSMS.

Complaints have been that the Board did not do an effective job in weeding out "bad" doctors, that it had a large backlog of uncompleted cases, that its processes are cumbersome and not always fair.

The bulk of physicians' fees, which fund the Board's work, have been diverted by the state, making it difficult to fully staff the Board and help it catch up on backlogged cases. Its procedures are set by law and have to be followed despite the fact they sometimes make it difficult to stop the improper practice of medicine. Board members themselves are not immune from lawsuits, which puts severe constraints on their activities.

All of these problems have been the subject over the years of MSMS meetings with the Board, as MSMS sought to help the Board develop more strength, better organization and freedom to act.

Elizabeth Howe, director, Department of Licensing and Regulation, finally convened a special state committee to study the issue.

On April 6, the committee made recommendations for major changes in the state's handling of complaints against medical practitioners. The Health Occupations Council of the Department of Licensing and Regulation now is considering the recommendations.

The special committee called for a restructuring of the Bureau of Health Services, which administrates the Board; and a new system to speed up and set priorities on complaint investigations.

According to the Gongwer News Service, Inc., DLR Director Howe commended the council's work, saying the department already had begun implementing some of the recommendations. She added, "with implementation of (Governor Blanchard's) budget, your recommendations can and will become the basis for a modern Bureau of Health Services."

The council has been investigating both the complaint processing operations of the bureau and the licensing operation since November. A preliminary report on complaint handling was made in February. This report contains the final recommendations on complaints and a preliminary report on licensing.

Among the recommendations was a restructuring of the health services bureau into two divisions, each under an assistant director, to monitor complaints and handle licensing matters. The complaint analysis system, and the investigation of allegations against professionals, must be restructured to better set priorities for investigations, the report says.

The recommendations also call for improved communications between the bureau and other enforcement agencies, such as the State Police, along with development of a consumer education system on medical complaints.

New job descriptions and procedures must be developed in line with the restructuring, the proposals say, along with assigning at least one assistant attorney general to the bureau.

In addition, the recommendations call for a "crash program" to be developed to handle the backlog of complaints already in the system prior to the new system under development. The recommendations propose an electronic data system to handle complaint information.

The committee also made a series of legislative recommendations, including proposals that would allow a board to order restitution to a complaining patient, providing immunity to the various health board members, and specifying that a portion of licensing fees go specifically to the department rather than to the state general fund.

The committee also said if a new court rule — which requires the court to consider the possibility of harm to the general public before ruling on an injunction brought by a health care professional — fails to stem the number of injunctions that block disciplinary orders, the Legislature should consider a statute that limits court injunctions.

Many of the preliminary licensing recommendations paralleled those for complaint processing, including restructuring the bureau, implementing an electronic data service, and changing employee procedures. But the preliminary recommendations also call for setting examination scores that reflect minimum performance standards, revamping the license renewal process to avoid delays, replacing current automatic revocation of a license for failure to renew with a "more reasonable and defensible provision," and monitoring compliance with continuing education requirements through a random audit system following license renewal.

1953.

- General Dwight D. Eisenhower was inaugurated President of the United States; his vice president was Richard M. Nixon.
- The Korean armistice was signed to end the Korean War.
- Not one home owned an electronic calculator or color TV.
- It cost 3¢ to mail a letter.
- The Studebaker was the "new American car with the European look."
- Jacqueline Bouvier was engaged to U.S. Senator John F. Kennedy; **and**
- **the Stratton Agency began serving the Michigan State Medical Society!**

We have appreciated your participation and support over the past 30 years. If you would like additional information about our services, we would be happy to hear from you.

STRATTON-CHEESEMAN & ASSOCIATES, INC.
1305 Abbott Road, P.O. Box 1563
East Lansing, Michigan 48823

800-292-1926

Competence counts

Hurley Medical Center photo

In selecting a doctor, 74 percent of Americans consider competence, not cost.

Competent doctors remain the key to health. But competence isn't immunity to litigation.

Consider our competence – and our professional liability protection and strong-defense philosophy.

We defend you against non-meritorious claims. We won't settle a claim without your approval or merely to cut our defense cost.

PICOM
Physicians Insurance Company Of Michigan
4277 Okemos Rd., Box 1000
Okemos, Michigan 48864

(517) 349-6500
(313) 557-4845
1-800-292-1036

TAKE A BREAK EACH WEDNESDAY

Your FREE HCN Coffee Cup!

with **Health Care News**, the most accurate, reliable, and complete way to keep abreast of health care regulations, legislation, mergers, moves, negotiations, people, continuing education, and job opportunities. We give you the news you need to know **52 times a year for only $11. $20 for 2 years & a free coffee cup.**

Health Care News

SERVING MICHIGAN'S HEALTH CARE PROFESSIONALS

Subscribe now. Limited time only.

☐ Payment Enclosed Firm Name (if applicable) ______
☐ New Name ______
☐ Renewal Address ______
☐ Bill me— $1.50 additional City/State/Zip ______
Interbank # ______ Exp. Date ______
☐ Bill firm—$1.50 additional
Signature ______
☐ Visa ☐ Mastercard
Drivers License Number ______

5440 Cass Avenue • Detroit, Michigan 48202 • (Phone (313) 831-3323
Telephone Orders Accepted

Medical Director Chemical Dependency Facility

Catherine McAuley Health Center (C.M.H.C.) is seeking a Medical Director for our new Chemical Dependency Programs which include a 40-bed adult and adolescent primary residential treatment program and a 16-bed intermediate primary residential program for adolescents.

Candidates will be Board certified or eligible (with certification achieved in two years) in a medical specialty. Michigan licensure will be required. Three to five years' clinical experience in chemical dependency treatment required. Medical administrative experience in a chemical dependency program highly desirable.

In addition to the new Chemical Dependency treatment programs, C.M.H.C. also consists of St.Joseph Mercy Hospital, a 558-bed community/teaching acute care hospital; Mercywood Hospital, a 135-bed short-term acute care psychiatric hospital and two out-patient satellites; Maple Health Building which provides minor emergency services, health promotion and ambulatory mental health services; and an Ambulatory Surgery Facility, and an employee Child Care Facility.

Candidates should submit resumes by July 2, 1984 to Dr. J.H. Carman, c/o Employment Office, (313) 572-3296. An Equal Opportunity Employer.

Catherine McAuley Health Center

Catherine McAuley Health Center
P.O. Box 995
Ann Arbor, Michigan 48106

Sponsored by the Religious Sisters of Mercy founded in 1831 by Catherine McAuley

By Joyce Crum

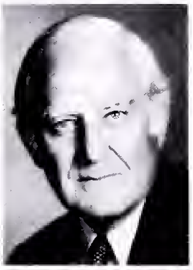
Bookstein

Brody

Coskey

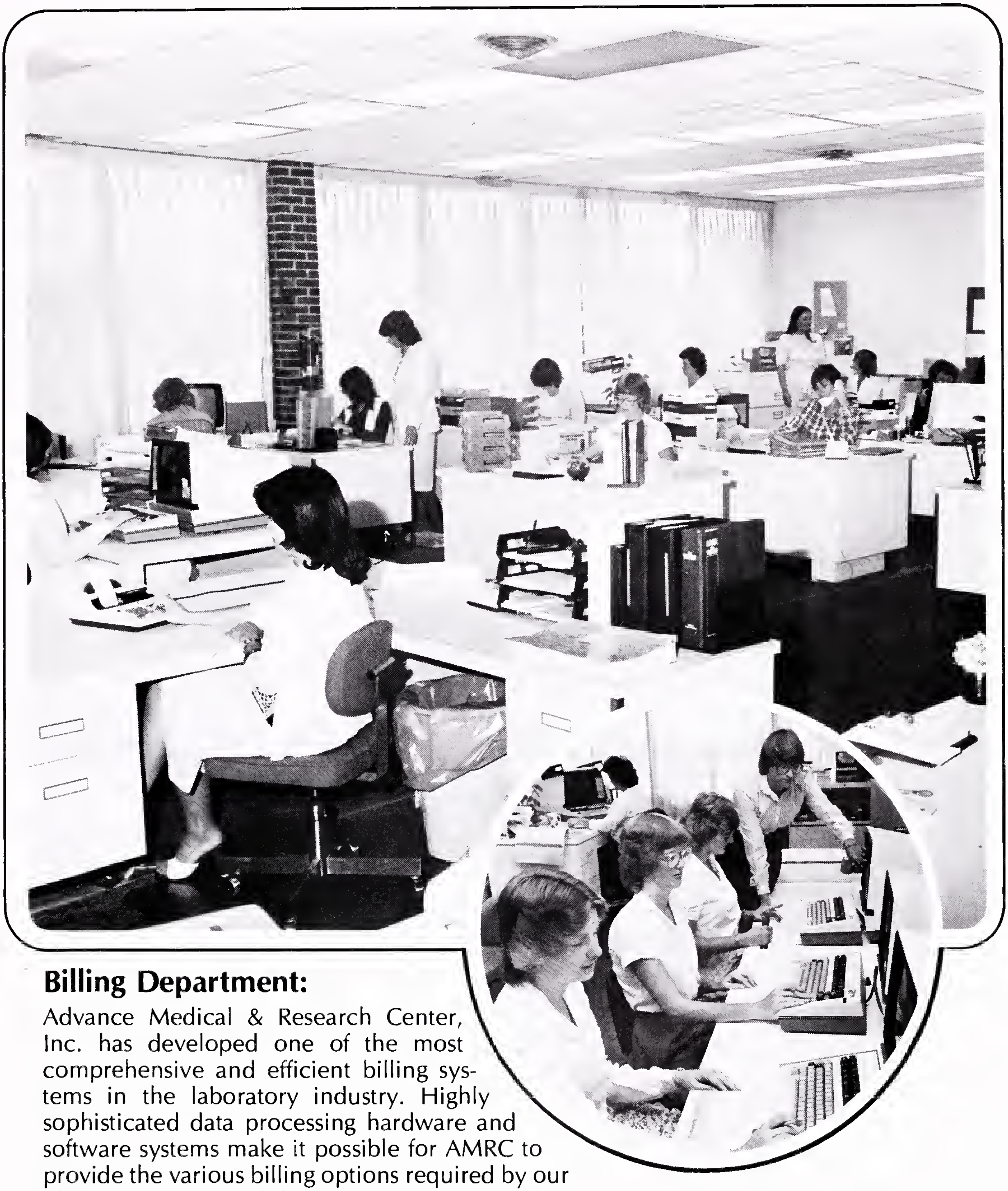
Perlmutter

Steffenson



Walt

Wallace H. Steffenson, MD, Grand Rapids, received the Honorary Citation, the highest award presented by the American Society of Plastic and Reconstructive Surgeons, at its Annual Scientific Meeting recently. Doctor Steffenson served as president of the ASPRS in 1958 and as chairman of the American Board of Plastic Surgery ... Newly installed as president of the Wayne State University School of Medicine Alumni Association is **Ralph J. Coskey, MD,** Southfield. Doctor Coskey is a graduate of the class of 1955 and is in the private practice of dermatology ... **Frank Nesi, MD,** Southfield, vice chief of ophthalmology at Grace Hospital, has co-authored a new book, "Practical Techniques on Ophthalmic Plastic Surgery," with Bryon C. Smith, MD, of New York. The book is published by C. B. Mosby Co., St. Louis, Missouri and V. B. Medical Publishing Ltd., London ... Awarded a Teacher-Scholar Award at Michigan State University for devotion and skill in undergraduate teaching is **Howard Brody, MD,** East Lansing. The MSU News Bulletin says of Doctor Brody that he "is a superb lecturer and a physician who has bridged the road between science and philosophy. His two books and numerous articles have earned him a national reputation." The award carries with it a $1,500 grant. ... In his capacity as chief of staff of Harper/Grace Hospital, **Robert W. Black, MD,** Grosse Pointe, has been appointed to the strategic management group. He will represent the interests of the medical staff in the deliberations of the senior executive group ... A yearly trip to Honduras to minister to the needy is like a working vacation, says **Fleming Barbour, MD,** Flint. He and his wife, Marian, just completed their annual trip with the Christian Medical Society, ministering to more than 3,000 Hondurans during two weeks in La Ceiba ... **Irene Auberlin,** 87, founder of World Medical Relief Inc., Detroit, will receive a Volunteer Action Award from President Reagan. Her volunteer agency has sent an estimated $500 million worth of supplies and equipment to treat sick people around the globe since 1953. ... The April 1984 issue of *Nebraska Medical Journal* featured a special article entitled "The Opportunities for Medical Statesmanship in Our Society" by **Alfred B. Swanson, MD,** Grand Rapids. Doctor Swanson, who is celebrating his 30th anniversary of practice in Grand Rapids, has been traveling to such places as Winnipeg; Atlanta; the University of Brescia, Italy, and Philadelphia, recently to lecture. He was the honored lecturer at an international symposium held in London, England ... **Hushang Payan, MD,** Ishpeming, co-authored an article that appeared in the February issue of *The Archives of Pathology and Laboratory Medicine.* The article, titled "Granulomatous Cornar Arteritis," studies one of the fewer than 25 such cases reported in medical history. Enid Gilbert, MD, professor of pathology at the University of Wisconsin in Madison cooperated on the article ... **Thomas E. Knuff, MD,** Marquette and **Gary L. Johnson, MD,** Ironwood, are new appointees to the board of directors of the Upper Peninsula Health Education Corporation ... The Young Careerist title of Ottawa County belongs to **Michelle Marie Condon, MD,** Grand Haven. This program recognizes the achievement of young women between the ages of 21 and 30 ... **Stefan S. Fajans, MD,** Ann Arbor, has earned the American College of Physicians' Mastership status, awarded at ACP's scientific meeting. He is honored for his research in diabetes mellitus. Only 150 have the rank of ACP Master out of the 60,000 ACP members ... **Bernard W. Agranoff, MD,** Ann Arbor, is new scientific director of the University of Michigan's Mental Health Research Institute. He will be responsible for guiding the institute's research programs ... Former Michigan physician **Joseph J. Bookstein, MD,** La Jolla, California, is 1984 Distinguished Alumnus of the Wayne State University School of Medicine. He is a graduate of the class of 1954 and is currently professor of radiology and chief of vascular radiology at the University of California, San Diego, Medical Center ... **Alexander J. Walt, MB, ChB,** is recipient of the Wayne State University School of Medicine Alumni Association's Lawrence M. Weiner Award for outstanding achievement of a non-alumnus. Doctor Walt is the Penberthy professor and chairman of surgery at the Wayne State University School of Medicine. He has been visiting professor at all the major medical schools in the country ... Newly elected as president of the American Board of Urology and of the Society for Pediatric Urology is **Alan D. Perlmutter, MD,** Detroit.



Billing Department:
Advance Medical & Research Center, Inc. has developed one of the most comprehensive and efficient billing systems in the laboratory industry. Highly sophisticated data processing hardware and software systems make it possible for AMRC to provide the various billing options required by our physician clients and their patients.

ADVANCE MEDICAL & RESEARCH CENTER, INC.
1270 Doris Rd. • Pontiac, Michigan 48057 • (313) 373-9120
Branches: Allen Park, Alpena, East Jordan, Flint,
Grand Rapids, Kalamazoo, Lansing, Monroe, Traverse City

Serving the medical profession since 1963

CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, (517) 337-1351.

Date: June 11-15, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsors:** MSU Colleges of Osteopathic Medicine and Human Medicine, and the North American Academy of Manipulative Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

Date: June 14-15, Clinical Laboratory Computers: Symposium 1984. Location: Towsley Center. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor, 48109 (313) 763-1400. **Approved for:** 11 hours of Category I Credit.

Date: June 15, Michigan Chapter, American College of Surgeons, Scientific Session. Location: Grand Traverse Resort, Traverse City. **Sponsor:** Michigan Chapter, American College of Surgeons. **Contact:** Vi Heins, MSMS headquarters, East Lansing. **Approved for:** 10 hours of Category I Credit.

Date: June 15-16, The Management of Medical Emergencies. Location: Grand Hotel, Mackinac Island. **Sponsor:** MSU College of Osteopathic Medicine. **For:** DOs and MDs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing, 48824 (517) 353-9714. **Approved for:** 10 hours of Category I Credit.

Date: June 15-16, Traverse City Trauma Symposium, Scientific Session. Location: Grand Traverse Resort. **Sponsor:** Michigan Committee on Trauma, ACS, Michigan Chapter American College of Surgeons, Wayne State University. **Cost:** $35.00. **Contact:** B.E. Henig, MD, Keyport Clinic, PO Box 605, Grayling, 49738, (517) 348-6611. **Approved for:** 4 hours of Category I Credit.

Date: June 24-29, 20th Annual Northern Michigan Summer Conference: An Update on Common Clinical Concerns. Location: Hilton Shanty Creek, Bellaire. **Sponsor:** U-M Office of Continuing Medical Education. **Contact:** Office of CME, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 20 hours of Category I Credit.

Date: July 8-10, Bi-annual Meeting, Michigan Academy of Plastic Surgery. Location: Mackinac Island. **Sponsor:** Michigan Academy of Plastic Surgery. **Contact:** Joseph Mark, MD, Michigan Academy of Plastic Surgeons, 1900 Wealthy Street, SE, Grand Rapids, 49506. **Approved for:** 6 hours of Category I Credit.

Date: July 9-11, Eleventh Michigan Emergency Medicine Assembly, Advances in Emergency Care. Location: Mackinac Island. **Sponsor:** American College of Emergency Physicians. **Contact:** Michigan ACEP, 1305 Abbott Road, Suite 104, East Lansing 48823. **Approved for:** 15 hours of Category I Credit.

Date: July 19-22, Macula Disease. Location: Mackinac Island. **Sponsor:** Michigan Ophthalmological Society. **Contact:** Leslie E. Meissner, MOS Administrator, 302 Eastland Professional Building, Harper Woods, 48225. **Approved for:** 8 hours of Category I Credit.

Date: July 23-25, 38th Annual Scientific Assembly. Location: Traverse City. **Sponsor:** Michigan Academy of Family Physicians. **Contact:** Dru Love, Executive Secretary, Michigan Academy of Family Physicians, 109 E. Oakland, Lansing, 48906. **Approved for:** 15.75 hours of Category I Credit (19-Wyeth Autotutors, 16-ACLS Course).

Date: July 26-27, Coller Penberthy Thirlby Medical Conference. Location: Park Place Hotel, Traverse City. **Sponsor:** Munson Medical Center. **For:** All interested physicians. **Contact:** Norma Powers, Coordinator of Medical Education, Munson Medical Center, 6th and Madison Streets, Traverse City 49684 (616) 922-9544. **Approved for:** 9 hours of Category I Credit.

Date: August 13-17, Tutorial on Direction Action Thrust Manipulative Therapy. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU College of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

Date: September 8, Pediatric Endocrinology. Location: St. John Hospital. **Sponsor:** CME Committee of St. John Hospital. **For:** Interested physicians. **Cost:** $90.00. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road, Detroit 48236 (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: September 8-12, Fundamental of Muscle Energy. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU College of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

Date: September 10-12, Hemodynamic Monitoring. Location: Towsley Center, Ann Arbor. **Sponsor:** U-M Dept. of Pathology and Office of Continuing Medical Education. **Contact:** Office of CME, Towsley Center, Box 057, U-M Medical School, Ann Arbor, 48109, (313) 763-1400. **Approved for:** 14.5 hours of Category I Credit.

Date: September 21-23, Tutorial on Myofascial Release Technique. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 24 hours of Category I Credit.

Date: October 6-10, Advanced Muscle Energy Tutorial (Above Diaphragm). Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

Date: October 17, Influencing Unfavorable Pregnancy Outcomes. Location: St. John Hospital. **Sponsor:** CME Committee of St. John Hospital. **For:** Interested physicians. **Costs:** $90.00. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road,Detroit 48236 (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: October 25-27, 15th Annual International Symposium on Implant Surgery for the Hand and Upper Extremity. Location: Blodgett Memorial Medical Center and Amway Grand Plaza Hotel, Grand Rapids. **Sponsor:** American Society for Surgery of the Hand. **Contact:** Alfred B. Swanson, MD, 290 Blodgett Professional Building, 1900 Wealthy Street, SE, Grand Rapids, 49506 (616) 774-7394. **Approved for:** 19 hours of Category I Credit.

Date: October 26-28, Manual Medicine Principles Applied to the Extremities. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 24 hours of Category I Credit.

Date: October 27, Annual Meeting of Michigan Neurological Association. Location: Botsford Inn, Farmington. **Contact:** Raymond B. Bauer, MD, 4201 St. Antoine 6G, Detroit 48201 (313) 494-4281. **Approved for:** 4 hours of Category I Credit.

Date: November 13, 14 & 15, Annual Scientific Meeting. Location: Hyatt Regency Dearborn. **Sponsor:** Michigan State Medical Society. **For:** All interested physicians. **Contact:** MSMS headquarters (517) 337-1351. **Approved for:** Maximum of 18 hours of Category I Credit.

Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

In Hypertension*... When You Need to Conserve K^+

Remember the Unique Red and White Capsule: Your Assurance of SK&F Quality

Serum K^+ and BUN should be checked periodically (see Warnings and Precautions).

Potassium-Sparing

DYAZIDE®

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

Over 17 Years of Confidence

The unique
red and white
Dyazide® capsule:
Your assurance of
SK&F quality.

a product of
SK&F CO.
Carolina, P.R. 00630

©SK&F Co., 1983

Motrin®
ibuprofen, Upjohn
600 mg Tablets

MOTRIN 600mg
MOTRIN 600mg
MOTRIN 600mg
MOTRIN 600mg
MOTRIN 600mg

More convenient for your patients.

Upjohn

©1984 The Upjohn Company
The Upjohn Company • Kalamazoo, Michigan 49001 USA
J 4044 January 1984

VICE PRESIDENT

Medical Services

Pontiac General Hospital, a progressive 388-bed teaching hospital located in Oakland County, is seeking a Vice-President, Medical Services, to act as liaison between the medical staff and administration and maintain medical educational standards of the Hospital.

As chief medical administrative officer of hospital administration and an officer of the medical staff, your responsibilities will include advising medical staff regarding bylaws, rules and regulations, and serving as staff representative to the medical staff bylaws committee. You will also represent the hospital and medical staff on numerous medical, administrative and community committees and promote a proper level of patient care for all patients.

Requirements for this highly specialized position include current medical license and certification in a medical specialty, appropriate administrative experience and demonstrated commitment to quality patient care. You must also either presently be a member or subsequently approved to the medical staff of Pontiac General Hospital.

Total compensation package is individually negotiable based on candidate's background and experience. Responses should be directed to the Search Committee, Medical Services Office:

PGH

Pontiac General Hospital
Seminole at West Huron
Pontiac, Michigan 48053

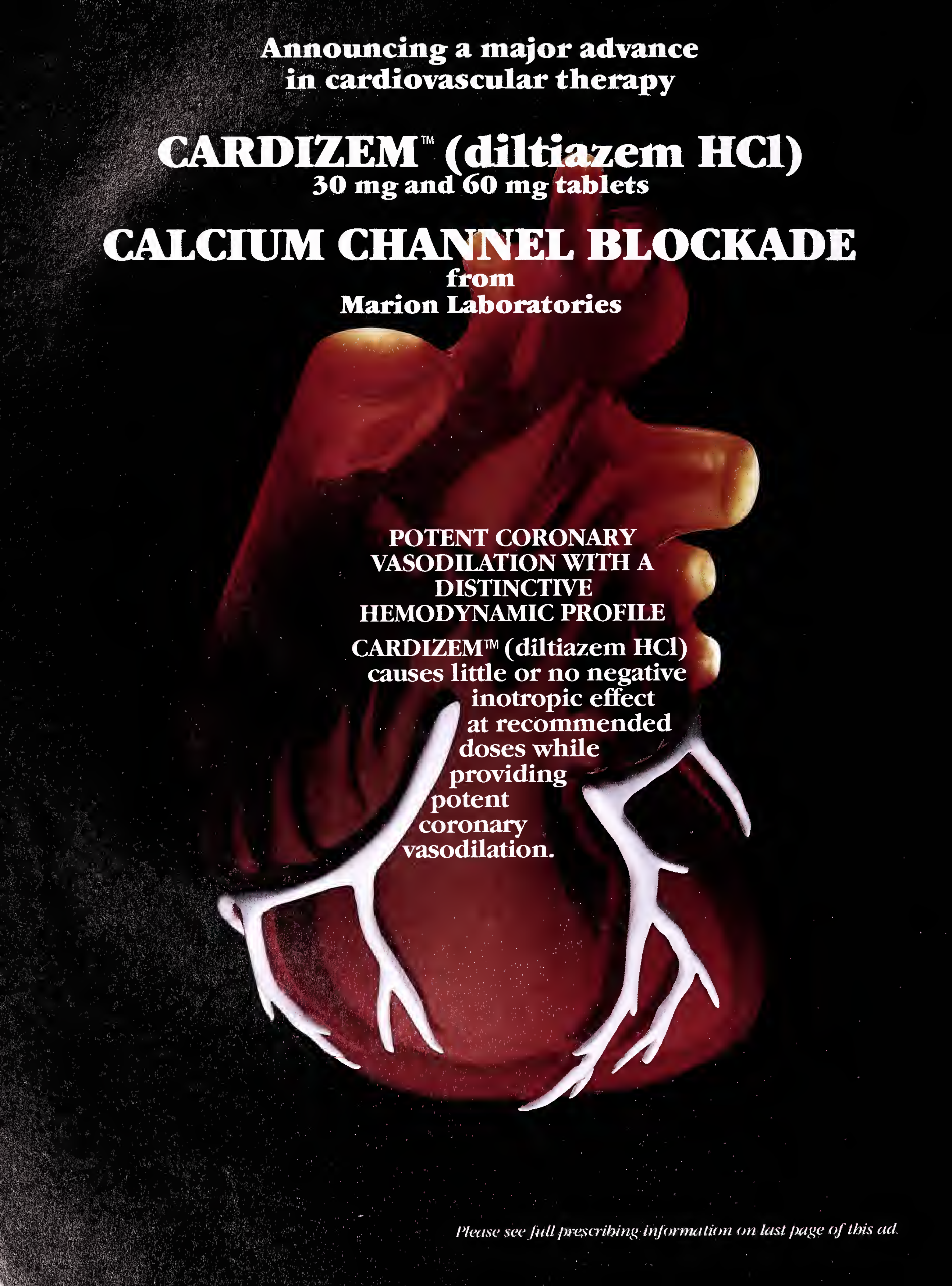
Affirmative Action/Equal Opportunity Employer

Do you know

a physician
with problems
of alcoholism,
drug abuse,
emotional illness
or other
difficulties
which interfere with
his or her ability
to practice medicine?

If so, please contact your MSMS Program to Assist Impaired Physicians through Katie Brewbaker at MSMS headquarters, (517) 337-1351.

MICHIGAN STATE MEDICAL SOCIETY
1866



Announcing a major advance
in cardiovascular therapy

CARDIZEM™ (diltiazem HCl)

30 mg and 60 mg tablets

CALCIUM CHANNEL BLOCKADE

from
Marion Laboratories

POTENT CORONARY VASODILATION WITH A DISTINCTIVE HEMODYNAMIC PROFILE

CARDIZEM™ (diltiazem HCl) causes little or no negative inotropic effect at recommended doses while providing potent coronary vasodilation.

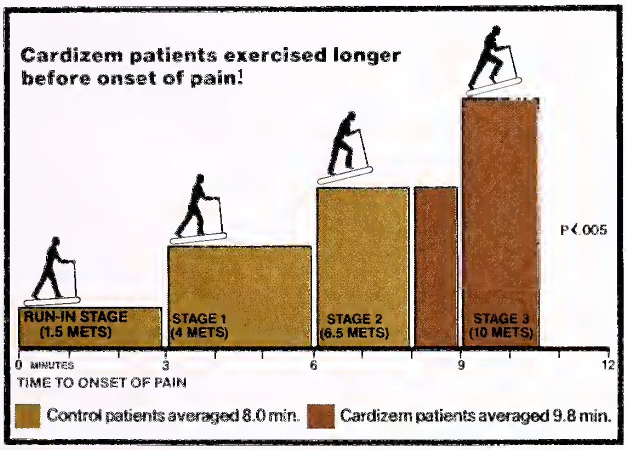
Please see full prescribing information on last page of this ad.

cardizem™
(diltiazem HCl)
30 mg and 60 mg tablets

INCREASES EXERCISE TOLERANCE, REDUCES ANGINAL FREQUENCY* WITH A LOW INCIDENCE OF SIDE EFFECTS

Calcium channel blockade with CARDIZEM™ (diltiazem HCl) produces changes in cardiovascular hemodynamics and coronary blood flow that are of benefit in myocardial ischemia.

CARDIZEM™ (diltiazem HCl) ALLOWS PATIENTS TO SIGNIFICANTLY PROLONG EXERCISE TOLERANCE, EVEN IN DEMANDING BRUCE PROTOCOL EXERCISE TESTS[1] (n = 15)†



This study is of special significance because patients not only exercised longer but *to the next higher stage* in the Bruce protocol.

A Bruce protocol with a run-in stage was used for all tests. Each stage lasts three minutes.

In other studies, Cardizem produced 41% to 68% reduction of Prinzmetal's variant angina attacks[2]

†This study is a report from one center in a multicenter study.

Therapy with Cardizem produced a low incidence of side effects.

In placebo-controlled trials (222 patients) conducted in the United States, the incidence of adverse reactions reported during Cardizem therapy was not greater than that reported during placebo therapy.

Those adverse reactions reported most frequently with Cardizem in 959 patients in controlled and uncontrolled U.S. trials have been:

• Nausea	2.7%
• Swelling/edema	2.4%
• Arrhythmia	2.0%
• Headache	2.0%
• Rash	1.8%
• Fatigue	1.1%

Other reactions reported infrequently (less than 1%) are listed in full prescribing information on adjacent page.

Please see adjacent page for full prescribing information.

References:
1. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. *Chest* 78 (July suppl): 234-238, 1980.
2. Schroeder JS, Feldman RL, Giles TD, et al: Multiclinic controlled trial of diltiazem for Prinzmetal's angina. *Am J Med* 72:227-232, 1982.

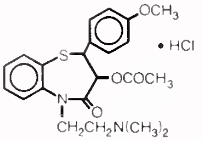
© 1983, Marion Laboratories, Inc.

PROFESSIONAL USE INFORMATION

cardizem™
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM™ (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy)-5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+)-cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate/blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent as a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents. CARDIZEM has been effective in short-term controlled trials in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness is incomplete.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (four of 959 patients for 0.42%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** There has been a single report in a patient receiving 120 mg of diltiazem tid of marked transaminase elevation (SGOT 4500, SGPT 2300) accompanied by hyperbilirubinemia (to 3 mg%), occurring after four days of treatment. The enzyme abnormalities resolved entirely, and enzymes were nearly normal a week after cessation of treatment. No rechallenge was carried out, but the patient had no evidence of viral hepatitis and received no other drugs but isosorbide dinitrate.

   No other similar liver injury has been reported in clinical trials, but marketing experience in Europe has resulted in a rechallenge-confirmed instance of hepatocellular injury. However, it should be noted that there have been further episodes of raised transaminases in the absence of diltiazem in this patient, so that the relationship to diltiazem of the abnormalities is not completely clear. Other instances of transaminase elevation have been reported in Europe, but their relationship to the drug is uncertain.

PRECAUTIONS

General. CARDIZEM is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities; the effect of diltiazem on serum digoxin levels has not been examined. The safety of the combination of CARDIZEM and beta-blockers or digitalis is currently being investigated in well-controlled studies.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded. Experience with an added beta-blocker is also extremely limited.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

In addition, the following have been reported infrequently and represent occurrences which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are nausea (2.7%), swelling/edema (2.4%), arrhythmia (2.0%), headache (2.0%), rash (1.8%), and fatigue (1.1%). In addition, the following events were reported infrequently (<1.0%). The order of presentation corresponds to the relative frequency of occurrence.

Cardiovascular:	Flushing, congestive heart failure, bradycardia, hypotension, syncope, pounding heart.
Central Nervous System:	Drowsiness, dizziness, lightheadedness, nervousness, depression, weakness, insomnia, confusion, hallucinations.
Gastrointestinal:	Vomiting, diarrhea, gastric upset, constipation, indigestion, pyrosis.
Dermatologic:	Pruritus, petechiae, urticaria.
Other:	Photosensitivity, nocturia, thirst, paresthesias, polyuria, osteoarticular pain.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

Experience in 959 patients taking oral doses of CARDIZEM resulted in three cases (0.31%) of second-degree AV block and one case (0.10%) of third-degree AV block at doses of 240 to 360 mg daily.

In rare instances, mild to moderate transient elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK have been noted during CARDIZEM therapy. A single incident of markedly elevated liver enzymes associated with symptoms was reported in a patient taking 360 mg per day for four days. Drug was discontinued and enzymes normalized within 1 week.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experiences with oral diltiazem have not been reported. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually to 240 mg (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. The effectiveness and safety of dosages exceeding 240 mg per day are currently being investigated. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents.

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy** — CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

CARDIZEM 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 11/82

Another patient benefit product from

PHARMACEUTICAL DIVISION
MARION
LABORATORIES, INC.
KANSAS CITY MISSOURI 64137

3/83

MSMS, MSMS/A, AMA, and medical assistants

June 17-21 — AMA Annual Meeting of House of Delegates, Chicago, contact: Bruce Ambrose, MSMS headquarters.

June 27 — MSMS practice management seminar for medical assistants, Saginaw, contact: Kirk McMurray, MSMS headquarters.

July 18 — MSMS practice management seminar for medical assistants, Flint, contact: Kirk McMurray, MSMS headquarters.

July 26-29 — Midsummer Meeting, MSMS Board of Directors, Deer Lake, Boyne Mountain, contact: Warren F. Tryloff, MSMS headquarters.

August 1 — MSMS practice management seminar for medical assistants, Southfield, contact: Kirk McMurray, MSMS headquarters.

Sept. 19 — MSMS Board of Directors meeting, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Nov. 13-15 — MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn, contact: Sherry Fent, MSMS headquarters.

Other meetings

June 15-17 — Michigan Dermatological Society, Grand Hotel, Mackinac Island, contact: Debbie Sanalis, 1015 Fernwood, Royal Oak, (313) 544-1891.

June 23-27 — Michigan Environmental Health Association Annual Educational Conference. The Amway Grand Plaza, Grand Rapids, contact: William E. DeHann, Michigan Environmental Health Association, (616) 774-3089.

June 24-27 — National Environmental Health Association Annual Educational Conference, Grand Rapids, contact: NEHA, 1200 Lincoln, #704, Denver, CO 80203 (313) 861-9090.

June 29-30 — Michigan Orthopaedic Society, Hidden Valley Resort, Gaylord, contact: John A. Henke, MD, Secretary-Treasurer, MI Orthopaedic Society, 413 Mecosta, Big Rapids 49307.

July 14 — Pakistani Physicians of North America, Detroit, contact: Amanullah Khan, MD, President, Association of Pakistani Physicians, 800 Eighth Avenue, Suite 200, Fort Worth, Texas 76104.

July 23-25 — 38th Annual Scientific Assembly, Traverse City, sponsored by Michigan Academy of Family Physicians, contact: Dru Love, Executive Secretary, Michigan Academy of Family Physicians, 109 E. Oakland, Lansing 48906.

August 9-12 — Michigan Psychiatric Society Scientific Meeting, Grand Traverse Resort, contact: MPS (313) 552-8666.

August 22-24 — Annual Meeting, Michigan Health Officers Association, Traverse City, contact: Bruce B. Bragg, President, MHOA, PO Box 24143, Lansing 48909.

October 11-14 — ACP/MSIM Annual Regional Scientific Meeting, Boyne Highlands Resort, Harbor Springs, sponsored by Michigan Chapter, American College of Physicians in association with Michigan Society of Internal Medicine, contact: Arnold R. Axelrod, MD, FACP, Department of Medicine, Sinai Hospital of Detroit, 6767 West Outer Drive, Detroit 48235 (517) 493-5780.

"It's going to be hard to fill your father's shoes . . . 40 years a doctor and not one malpractice suit!"

Thanks to our advertisers

AMRC	313
American Physician Life	295
Brown Pharmaceutical Company	287
Burroughs Wellcome	278
Catherine McAuley Health Center	311
CoAmerica	297
HASCO	305
Health Care News	311
Lab of Clinical Medicine	303
Eli Lilly	293
MPMLC	300-301
MSMS Program to Assist Impaired Physicians	317
Marion Lab	318-320
Medical Protective	323
PICOM	310
PSG/GTE MINET	IFC
Pontiac General Hospital	317
Professional Practice	321
Roche Laboratories	IBC-BC
Smith Kline & French Lab	315
Stratton-Cheeseman	309
Upjohn Company	316

PRACTICES FOR SALE

FAMILY PRACTICE—Mt. Clemens area. Beautiful equipment and office furniture. Practice is within large medical complex with complete radiology and blood work facilities. 2000 sq. ft.

DERMATOLOGY PRACTICE—Bloomfield Hills area. Well-established. Reasonable terms and down payment.

OBSTETRICS/GYNECOLOGY—Ann Arbor area. Take over a well-established practice. Excellent equipment, office furniture and building. Price and terms negotiable. Wonderful Opportunity!

FAMILY PRACTICE—Redford area. Excellent equipment and office furniture. Well-established practice. Building and rental included.

INTERNAL MEDICINE—East Detroit area. Big earnings, lots of equipment. MUST SEE!

MEDICAL PRACTICE—Lansing area. Industrial and family, good equipment. Also, building is optional. Great Opportunity.

Professional
Practice Sales, Inc.
27208 Southfield Road
Lathrup Village, Michigan 48076
HERBERT SILVERMAN, BROKER
(313) 569-7336

The rate for each classified advertisement in *Michigan Medicine* is 20¢ per word, with a minimum charge of $10.00. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

Positions Open

PHYSICIANS NEEDED IN NORTH CENTRAL MICHIGAN — Family Practice, Urology, Pediatric and Orthopedia Surgery physicians needed in Grayling. This rapidly growing, beautiful resort area with a service population of approximately 40,000 has a 90 bed acute care hospital with attached 40 bed long term care unit. Family Practice, Internal Medicine, OB/GYN, Orthopedic Surgery and General Surgery physicians practice here at present (with several consulting specialists). Financial assistance is negotiable. Some opportunities exist within established practices. Well-established churches, country club, 34 miles of cross country ski trails, 200 miles of unrestricted waters for trout fishing, 200,000 acres of natural open country for snowmobiling and two major ski and winter sports areas 55 miles from Traverse City. Interested physicians, please send CV or call Barbara Lester, Mercy Hospital, 1100 Michigan Avenue, Grayling,49738, (517) 348-5461.

PHYSICIAN PART-TIME (afternoons) for General Practice Clinic northeast of Lansing. No night call. No hospital work. Hours and salary negotiable. Send CV to 213 Mercer St., Durand, 48429.

GENERAL SURGEON, BOARD CERTIFIED or eligible, to join several doctor family practice Clinic in Cloquet, Minnesota, a community of 12,000 (30,000 service area) located 20 minutes from Duluth-Superior. Clinic facility is located one block from modern, well equipped 77 bed hospital. Cloquet enjoys a stable economy (forest products). Additionally, our community is noted for its excellent school system. First year salary guarantee, paid malpractice, health and disability insurance, vacation and study time. Contact John Turonie, Administrator, Raiter Clinic, Ltd., 417 Skyline Blvd., Cloquet, MN 55720. Telephone (218) 879-1271.

MICHIGAN TECHNOLOGICAL UNIVERSITY HEALTH SERVICE seeks a replacement primary care physician. The health facility is a medically oriented, ambulatory service, servicing a university student population of 7,500. Annual student visits are approximately 12,000. Liberal fringes, meeting allowance, and vacation benefits complement a competitive salary and allow adequate enjoyment of the rural all-season recreation area. Contact David Schwalm, PA-C, Administrator, Michigan Technological University Health Service, Houghton, 49931, or call (906) 487-2435. Michigan Technological University is an Equal Opportunity Educational Institution/ Equal Opportunity Employer.

ENDOCRINE FELLOWSHIP AVAILABLE July, 1984. Major affiliated hospital University of Michigan. Broad clinical experience, research opportunities. Reply with CV to Ramon R. Joseph, MD, Wayne County General Hospital, Westland 48185.

WANTED — A PSYCHIATRIST to join a busy practice of General Psychiatry. Excellent salary and fringe benefits. Send replies to Box 58, Michigan Medicine, 120 W. Saginaw, East Lansing 48823.

ASSISTANT DIRECTOR OF INTERNAL MEDICINE Education position available. 60-bed, university-affiliated hospital in the Midwest with a large Internal Medicine Residency Program seeks a Board Certified Internist (subspecialty not required) to teach Internal Medicine to residents and medical students and to assist the program director with administrative matters. University faculty appointment. "State of the Art" hospital facility. Excellent benefit package. Equal Opportunity Employer. Mail CV to: Administrative Director, Medical Education, Hurley Medical Center, One Hurley Plaza, Flint 48502.

OPERATING CORPORATION OF SEVERAL MEDICAL CENTERS providing primary care for senior citizens seeks Board Certified or Board Eligible, Florida licensed MDs with the following specialties . . . Family Practice, Internist, Cardiologist and Radiologist. Salary plus incentive. Insurances paid. Association fees paid. Contact Mr. Ed Hoke, H.S.C. Medical Centers, 1529 US 19 South, Levitz Center, Clearwater, FL 33546. Phone (813) 530-9455.

GASTROENTEROLOGIST — NEUROLOGIST — NEUROSURGEON: Independent group of private practitioners searching for an independent-practice oriented BC/BE gastroenterologist, neurologist, and neurosurgeon. Referral base includes 100 physicians, serving a population of 120,000. Unlimited recreational activities, medium sized university city. Immediate need. Chippewa Valley Independent Physicians, P.O. Box 1725, Eau Claire, Wisconsin 54702.

FAMILY PRACTICE (BATTLE CREEK) — Two man family practice seeking one or two physicians. Serving area of 100,000 with three open hospitals. Salary first year. Full partner after one year. Health insurance, disability insurance, pension and profit sharing plan, six weeks vacation. Inquire to Cinde Van Dusen, Capital Avenue Medical, PC, 719 Capital Avenue SW, Battle Creek 49015. Phone (616) 965-5188 (9am-5pm).

WANTED: Board certified or eligible Ophthalmologist to join general ophthalmology practice in Michigan's Upper Peninsula. Reply with Curriculum Vitae to: G. Richard Keskey, MD, Mid Peninsula Eye Clinic, 2600 College Avenue, Escanaba, 48929.

GENERAL SURGEON — Active two man surgical practice located near two large urban areas is looking for an allopathic or osteopathic trained, Board Eligible or Board Certified general surgeon. Please send curriculum vitae to Surgical Specialists, P.C., 544 North Main, Lapeer, 48446, (313) 664-4100.

MICHIGAN: EMERGENCY CONSULTANTS, INC. currently staffs Emergency Departments throughout the state. Full-time and part-time positions available in rural and urban locations. Guaranteed hourly rate plus malpractice insurance. Contact Emergency Consultants, Inc., 2240 South Airport Road, Suite 115, Traverse City 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

POSITIONS WITH THE STATE OF MICHIGAN — Currently taking applications for positions expected to be available in the future. Office locations now include Kalamazoo, Lansing, Southfield, and Traverse City. A board certified or board eligible psychiatrist needed for the Kalamazoo office, and internists with rheumatology or cardiology background desired for other offices. Beginning salary in low 60s with approximately 26% fringe benefits. An equal opportunity employer. All inquiries treated confidentially. For further details, please write: Harry D. Nesmith, MD, Chief Medical Consultant, Disability Determination Service, PO Box 30011, Lansing, 48909.

FAMILY PHYSICIAN: IMMEDIATE OPENING for a residency trained FP preferring small-town life style and interested in "whole person medicine from the Christian perspective" in a new office in the small college town of Hillsdale in southern Michigan. Write or call: Frederick L. Bean, MD, Hillsdale Family Practice, 111 South Howell, Hillsdale, 49242, (517) 437-7307.

Positions Wanted

OPHTHALMOLOGIST AVAILABLE for locum tenens. Board certified. Also interested in full-time or part-time position. Contact: Box 39, Michigan Medicine, 120 W. Saginaw, East Lansing 48823.

Miscellaneous

VIRGINIA HEART INSTITUTE provides on-site consultation for administrators interested in the development of ambulatory facilities including outpatient cardiac catherterization. If interested, write Patricia Ferree at Virginia Heart Institute, 205 N. Hamilton Street, Richmond, Va 23221.

SPORTFISHING CHARTERS AVAILABLE for salmon (Lake Michigan, Ludington and Frankfort) and walleye (Lake Erie, Monroe), aboard a 28 ′ Bertram cruiser. All tackle provided. For details, call 1-313-625-2730.

WELL ESTABLISHED (since 1966) private psychiatric practice for sale and/or OPC provider number. Also medical suite for lease or sale with the practice. Inquiries, please call Sue at (313) 644-0544, Birmingham.

PRACTICES WANTED — We have qualified purchasers looking to assume established MD, DO and DDS practices in Metro area. All inquiries confidential. Call Commonwealth Real Estate Group (313) 288-0022.

HEALTH FORCES SALE OF ACTIVE GENERAL Practice in Detroit. Grossing over $300,000. Call Commonwealth Real Estate Group, (313) 288-0022.

MEDICAL PRACTICE FOR SALE. Downtown Detroit area. Call Commonwealth Real Estate Group, (313) 288-0022.

WE HAVE QUALIFIED PURCHASERS LOOKING to purchase Nursing Homes in Michigan. All inquiries confidential. Call Commonwealth Real Estate Group, (313) 288-0022.

ACTIVE MEDICAL PRACTICE FOR SALE. Detroit Area. Grossing $200,000. Call Commonwealth Real Estate Group, (313) 288-0022.

MEDICAL PRACTICE FOR SALE. Located near Traverse City area. Doctor planning retirement. Call Commonwealth Real Estate Group, (313) 288-0022.

INCOME PRODUCING INVESTMENT FOR SALE. Prestigous 18,000 sq. ft. office building, fully leased. Near 11 Mile and Lahser. $684,000. Terms considered. Call Commonwealth Real Estate Group, (313) 288-0022.

FLINT AREA GENERAL PRACTICE FOR SALE. 7,000 patients seen in 1983 (part-time). Gross 175K. Physician could live in Flint, Lansing or surrounding area. Terms negotiable. Call (313) 674-1610 for information. Little local competition.

FOR SALE, SCHUSS MT. CHALET. Held off buying a northern Michigan vacation home because your wife objects to "roughing it?" This custom-build, professionally decorated, fully furnished 5 BR, 3 bath chalet will change her mind! Owner saves you $15,000. $164,900. Terms negotiable. Literature, showing appointment: (616) 587-9241.

MEDICAL OFFICE SPACE AVAILABLE the end of 1984. 2600 sq. feet of office space with shared waiting room. Linden Bristol Square, 5119 W. Bristol Road, Flint 48504. (313) 732-1620.

BIG TWIN LAKE, KALKASKA COUNTY — Custom ranch, 2000 sq. ft. luxury living. Features include wet bar, recreation room, fireplace, cedar walk-in closets, 3 bedrooms, 2½ baths, large deck area, 100 ft. sugar sand beach and much more. For sale by owner. Priced at $125,000.00. Phone (616) 587-8238.

EQUIPMENT WANTED: Am Furnishing 3 new examination rooms and need used equipment in good condition. Am interested in 2 clinical examination tables of the standard type for gynecologic examinations, 1 power Ritter table for proctoscopy and procedures. 3 hydrolic type physician's stools, and 3 treatment cabinets. Contact J. Phillips, MD, 802 E. Chicago Road, Sturgis 49091, (616) 651-4426.

USED LABORATORY EQUIPMENT like new, Chemtek, Celltract^5, Riaphase, and Centifuge (Clay-Adams). Call weekdays 9AM-7PM, (313) 557-3303.

MEDICAL/PROFESSIONAL BUILDINGS FOR SALE OR LEASE! Two buildings available in Prime Grand Rapids Locations. Approximately 2,000-3,000 sq. ft. Owner will lease all or part or will sell on 11% land contract. Doctor-owner will sacrifice to doctor starting practice or to established doctor wishing to purchase or expand to new facilities. MAKE OFFER! Call Mike Anderson at Liberty Realty (616) 455-7179.

HYANNIS, CAPE COD & NEWPORT, RI: Condo Rentals. Executive townhouses on beach. 3 bedroom, 3 bath, pool, tennis. Private decks. Country seclusion near city activities. $1,250 week summer. Off-season before June 16, after September 1. ST. THOMAS BEACHFRONT CONDO: 2 bedroom, 2 bath, $1,400 week season, $735 week off-season. (617) 678-2500.

IDEAL LOCATION heavy traffic — Strip Shopping Center. $600 per month — Walled Lake, share space with Podiatrist. Dr. S. Cyril Leib, DPM, 1266 S. Commerce Road, Walled Lake, 48088.

FOR LEASE — IN OAKLAND COUNTY in the beautiful lakes area of Union Lake and Walled Lake. Area is growing but with a solid base of older homes. New professional buildings in what will be "the" place to go for health and dental care. A place with an "identity." Custom designed suites from 1,200 to 6,000 s.f. Ideal for specialists as they are needed in this area. A great area to live in! For more information call (313) 363-3228 or 625-0660.

Rx PADS PRINTED to your specifications. $20.00 per thousand in pads of 100. $21.00 one time set up charge. Shipping additional. Small Craft Printing Company, 211 E. Kalamazoo St., Lansing, 48933 (517) 485-0553.

PREVIOUSLY OWNED MEDICAL LABORATORY AND OFFICE EQUIPMENT available in excellent condition. We buy, sell, trade, move and repair. Office assessments available by certified surgical consultants. Call Doctor Medical Resale, Ltd. (313) 569-4407, 9 AM to 9 PM.

SAIL BEAUTIFUL LITTLE TRAVERSE BAY — Lake Michigan Hagerman's Sailing School, Petoskey, MI. Two, three or five day courses of instruction for novices or new cruising sailors aboard a 27′ sloop $60 per person/per day. Skippered charters! Reserve preferred dates early. Write or call: 1630 Melrose, East Lansing, 48823 (517) 337-7009.

DOCTOR, YOU CAN'T BEAT THE QUALITY OR THE PRICE! Holter Monitor scanning service. Physician owned, trained and supervised. $35.00 for cassette reports; $45.00 for reel to reel reports; no contracts to sign. We can arrange for lease/purchase of Holter equipment. Why are you paying more and getting less? DCG Interpretation (313) 879-8860.

ATTENTION DOCTORS: We have previously owned medical, laboratory, office and x-ray equipment in excellent condition. We buy, sell, trade, move and repair. Office appraisals available by certified surgical consultants. Call Doctor Medical Resale at 313-569-4407, 9 am-9 pm.

PHYSICIAN SIGNATURE LOANS TO $50,000. Up to 7 years to repay. No repayment penalties. Prompt, courteous service. Competitive fixed rate, with no points, fees or charges of any kind. Physicians Service Association, Atlanta, GA. Toll-free (800) 241-6905.

Support our advertisers

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

1st FOR PROFESSIONAL PROTECTION EXCLUSIVELY

YOUR FIRST STEP TO FIRST QUALITY PROTECTION
CONTACT FIELD REPRESENTATIVES

Eastern Office
JOHN K. GALLOWAY, THOMAS A. WEISMAN, WAYNE M. BACKUS,
MARK A. TISDEL and CHARLES J. ROWE
6785 Telegraph Road, Suite 350, Birmingham, Michigan 48010
(313) 647-6640

Western Office
GEORGE J. HAWORTH
2600 Five Mile Road, NE, Suite 101
Grand Rapids, Michigan 49505
(616) 361-0863

Let us rededicate ourselves to our patients

The following article is taken from Doctor Zako's address, delivered when he was installed as MSMS president May 5 at the Amway Grand Plaza Hotel in Grand Rapids.

Louis R. Zako, MD
MSMS President

It is traditional at this time in the deliberations of the MSMS House of Delegates for the incoming president to share with the delegates his or her view of what needs to be done in the year ahead. The president generally outlines a program of action and speaks somewhat optimistically about proposed solutions to the major problems facing Michigan physicians.

With your permission, I would like to depart from that format.

Obviously, I could speak with some authority about escalating health care costs, about DRGs, about medical malpractice, and even about the doctor "glut." I could talk about the growing competition between physicians and between physicians and health care organizations such as hospitals, HMOs and PPOs. In my view, all of these are major and legitimate concerns for physicians. Although I personally do not have all of the answers, I do believe that MSMS and its leadership, including this House of Delegates, have the capability to deal effectively with each and every major issue facing our profession.

Define our mission

What MSMS cannot do for us and for our colleagues is to define our mission as individual physicians.

As obvious as it may seem, our primary responsibility as physicians is to care for our patients. Naturally we are concerned about the possibility of being sued; presently one in four of us is sued each year. Naturally we are distressed when we lose longstanding patients to an HMO or to a PPO. Nonetheless, like no one else on earth, each of us has the opportunity on a daily basis to provide competent and loving medical care for our patients.

We are privileged to save lives on a fairly regular basis:

To alleviate suffering daily.

To provide comfort and compassion to each and every one of our patients.

No doubt it is nice to easily finance our children's educations.

No doubt it is nice to drive a luxury car.

No doubt it is nice to play golf every Wednesday or every Thursday at the country club.

No doubt it would be very nice to eliminate the contingency fee in medical malpractice or to be able to countersue when the original suit was frivolous and without merit.

But are any or all of these of greater value than the love and devotion of a single patient?

Are any or all of these worth more than the satisfaction of having acted appropriately and courageously on behalf of our patients?

We really can't have it both ways. We can't lead lives which are materially comfortable and free of stress and at the same time remain strong patient advocates.

Do we continue to fight like hell for the kind of medical care we want for ourselves, our families and friends, and for our patients, or do we avoid the hassle of governmental and hospital intrusion into medical decision-making?

Do we practice "safe" defensive medicine or do we practice appropriate medicine and be willing to defend our judgment in court?

Do we join the next HMO or PPO that comes along or do we continue to provide more personalized care in a highly competitive and risky environment?

Actions, not rhetoric

Very few on this earth are as privileged as physicians. I urge you not to become so worldly, so sophisticated, so cynical that you and I gain a little and lose a lot. MSMS can and will effectively represent our professional interests. Let us physicians re-dedicate ourselves to our patients. Let us ultimately be judged by our actions, not by our rhetoric.

It is a deep privilege and an honor to serve as your president for the coming year. I pledge myself to serving you with humility, with dignity and with pride in what we represent.

COMPLETE LABORATORY DOCUMENTATION[1-5]... EXTENSIVE CLINICAL PROOF

FOR THE PREDICTABILITY CONFIRMED BY EXPERIENCE

DALMANE® Ⓒ
flurazepam HCl/Roche

THE COMPLETE HYPNOTIC PROVIDES ALL THESE BENEFITS:

- Rapid sleep onset[1-6]
- More total sleep time[1-6]
- Undiminished efficacy for at least 28 consecutive nights[2-4]
- Patients usually awake rested and refreshed[7-9]
- Avoids causing early awakenings or rebound insomnia after discontinuation of therapy[2,5,10-12]

Caution patients about driving, operating hazardous machinery or drinking alcohol during therapy. Limit dose to 15 mg in elderly or debilitated patients. Contraindicated during pregnancy.

DALMANE® Ⓒ
flurazepam HCl/Roche

References: 1. Kales J *et al*: *Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A *et al*: *Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A *et al*: *Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A *et al*: *Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol 3*:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **9.** Amrein R *et al*: *Drugs Exp Clin Res* 9(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol 3*:303-326, May 1981. **11.** Greenblatt DJ *et al*: *Sleep 5*(Suppl 1):S18-S27, 1982. **12.** Kales A *et al*: *Pharmacology 26*:121-137, 1983.

DALMANE® Ⓒ
flurazepam HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

DOCUMENTED IN THE SLEEP LABORATORY[1-5]...

PROVEN IN THE PATIENT'S HOME

FOR A COMPLETE NIGHT'S SLEEP

DALMANE® (IV)

flurazepam HCl/Roche

STANDS APART

15-MG/30-MG CAPSULES

See preceding page for references and summary of product information.

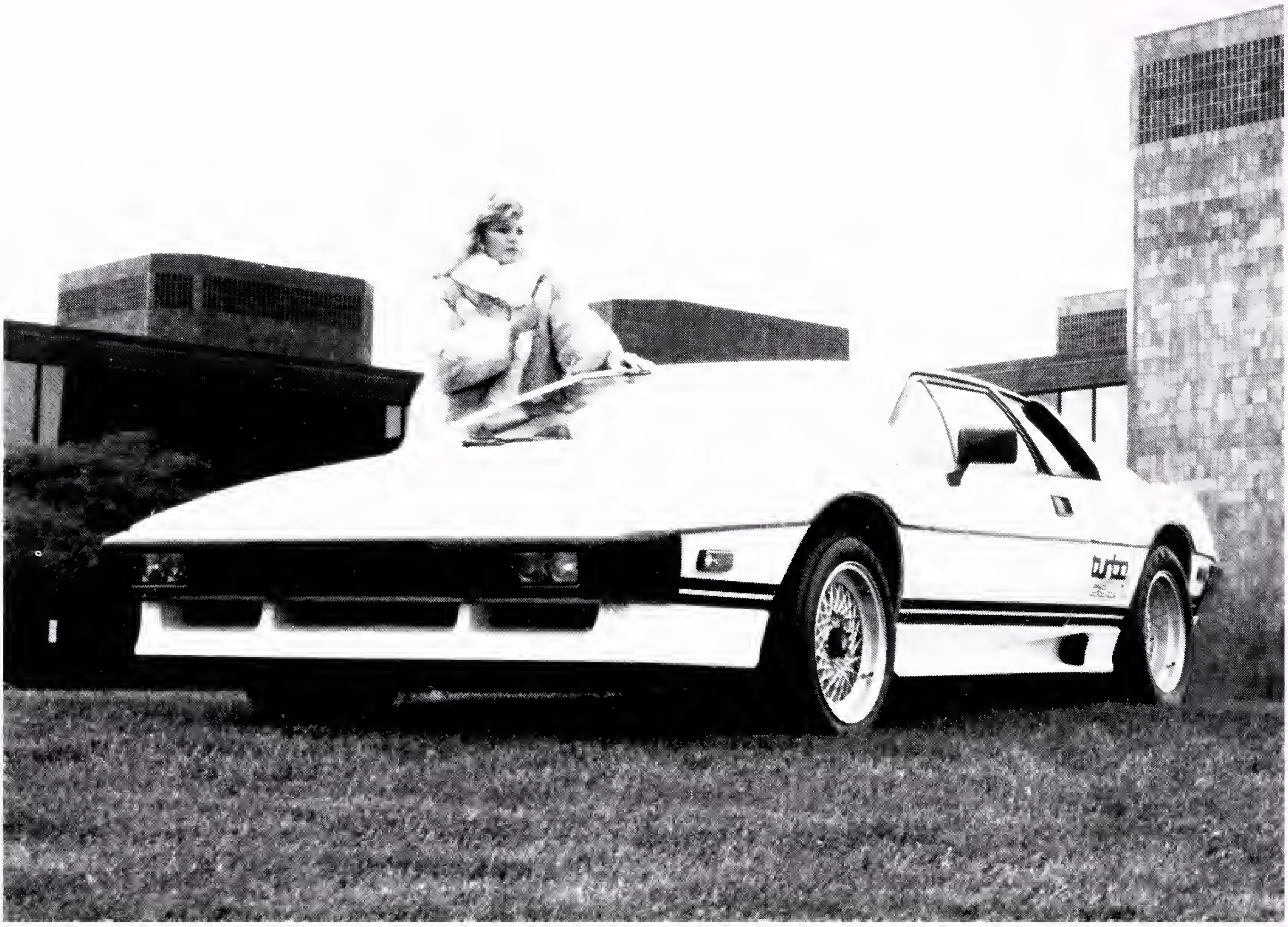
Copyright © 1984 by Roche Products Inc. All rights reserved.

MICHIGAN MEDICINE

July 1984 The award-winning JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Vol. 83, No. 34

WITH
ISSUES

225 00000000000 123184
SERIALS DEPT - LIBRARY
COLLEGE OF PHYS OF PHILA
19 SOUTH 22ND STREET
PHILADELPHIA, PA 19103
JUL 24 1984



Announce your arrival.

When you arrive in the Lotus Turbo Esprit, you're completing a trek that began almost three decades ago and has covered the road and race courses of four continents.

This 16-valve mid-engine masterpiece of the automaker's art delivers all the muscle, finesse and sophistication that any serious driver, road or track, could ask of the name Lotus.

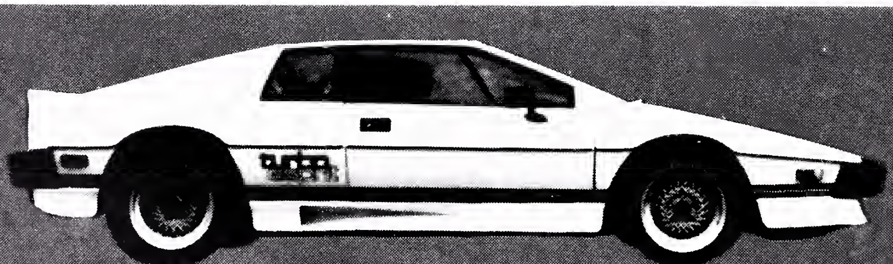
Wherever you're going, when you get there, be sure you arrive in a Lotus Turbo Esprit.

For further information on the Lotus Turbo Esprit,
write: LOTUS
Birmingham Motors, Ltd.
479 S. Woodward Avenue
Birmingham, Michigan 48011

Gentlemen:

I find the Lotus Turbo Esprit a most intriguing automobile. Please send me full particulars on this remarkable sports car.

Name ____________________
Address ____________________
City/State/Zip ____________________
Telephone ____________________



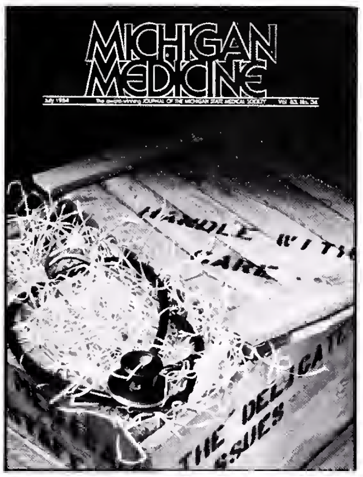
LOTUS

BIRMINGHAM MOTORS, LTD.

479 S. Woodward, Birmingham MI 48011 (313) 646-3980

July 1984, Vol. 83, No. 34

MICHIGAN MEDICINE



About the cover:

The packing crate harboring a stethoscope symbolizes the delicate issues of physician-hospital relationships today, the subject of this month's special report. Photo by Kim Kauffman.

Special report

328 How does your hospital grant privileges to physicians today? How does your hospital handle granting of privileges to non-physician practitioners? How does your hospital board receive physician input? These were the delicate questions put by *Michigan Medicine* recently to four physicians who are experts in the area of hospital-physician relationships. The four sat around a table to share their management experiences and skills in hopes of helping other physicians around the state cope with similar difficult situations. Their conversation about these issues was recorded and edited for our special report this month, which also contains legal advice from MSMS counsel and a description of the goals of the new MSMS Hospital Medical Staff Section; Judith Marr, Monte Jahnke, and William Madigan.

Features

340 MSMS puts new emphasis on practicing physician in its Annual Scientific Meeting

342 AMPAC and MDPAC make political education fun

344 MDPAC annual luncheon features Senate Majority Leader John M. Engler

348 Photo feature on 1984 MSMS House of Delegates meeting

Departments

326 In my opinion; Harvey M. Andre, MD

327 Letters

338 MSMS/A; Nancy Crandall

354 Meetings

359 Financial planning; Katharine Brown

362 New members

366 News

369 Category I courses

370 Board of Medicine disciplinary actions

372 Deaths

374 Classified ads

375 Ad index

376 President's page; Louis R. Zako, MD

In next month's
Michigan Medicine
How all specialties may work together to better provide emergency medical services throughout the state.

How MSMS House of Delegates conducts its business

By Harvey M. Andre, MD

You have read in the *Medigram* about some of the resolutions passed in the recent meeting of the House of Delegates. You have also been informed of the results of the elections.

But I do believe we have been remiss in past years by not informing the membership of how the various sessions of the House of Delegates are conducted. Maybe this summary of the order of business of the May, 1984 meeting of the House will give you some insight.

The first meeting was on Friday night, May 4. The meeting was called to order by the Speaker of the House and an invocation was given by one of the members. The Committee on Credentials reported on the number of delegates seated at that time.

The Chairman of the Committee on Rules and Order of Business then gave his report. Should there have been any urgent resolutions, not filed prior to 30 days before the meeting of the House, which were deemed of sufficient urgency, they then could have been recommended to be added to the resolutions already published.

Following that was a memorial for deceased delegates and new delegates were then introduced. Reports of the Chairmen of the Resident Physician and Medical Student sections were then given. The Chairman of the delegation to the AMA made his report.

The chairman of the MSMS Board presented his report followed by heads of PROM, MPMLC, and MDPAC. The MSMS President, Donald K. Crandall, Muskegon, then gave the Presidential Address. Presidential Citations were made, and the meeting adjourned.

On Saturday, May 5, the House reference committees met from 8:30 AM until noon. At these meetings, testimony for or against the resolutions is presented. The MDPAC annual luncheon was held at noon, featuring speakers from both the Republican and Democratic parties. The Wayne County and Outstate Caucuses followed the luncheon. Then, at 3 PM, the second meeting of the House was held. At this time awards are made to those physicians who have been in practice for 50 years, to presidents of state nonmedical associations, and to the presidents of various national medical groups. Following this the election of delegates and alternate delegates to the AMA took place, as well as the election of the various society officers. The incoming president, Louis R. Zako, MD, Dearborn Heights, was installed, and he described to the House as to his plans for the coming year.

On Saturday evening, MSMS staged the reception and banquet honoring the retiring president, Doctor Crandall, and the incoming president, Doctor Zako.

The Third Meeting of the House was held Sunday morning. The Reference committees recommended the delegates take various actions on the resolutions. The House then voted on each resolution, or combinations of resolutions. This process has been markedly streamlined from what it was some 15 or 20 years ago. The business of the House was finished about 1 PM, and final adjournment occurred.

Doctor Andre, of Grand Rapids, is chairman of the MSMS Committee on Publications. He has been a Kent County delegate to the MSMS annual meetings for 20 years.

Michigan State Medical Society
Warren F. Tryloff, director

Committee on Publications
Harvey Andre, MD, Grand Rapids, chairman
Frederick W. Bryant, MD, Royal Oak
Vickers C. Hansen, MD, Manistee
Leland E. Holly II, MD, Muskegon
Richard L. Rapport, MD, Flint
Marguerite Shearer, MD, Dexter
Louis R. Zako, MD, Dearborn Heights

Editor
Judith Marr

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

MICHIGAN MEDICINE (ISSN 0026-2293) is the official journal of the Michigan State Medical Society, published under the direction of the Publications Committee. Published five times a month, 60 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $30.00; single copies, $1.50. Additional postage: Canada, $1 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to articles, news, exchanges, should be addressed to Judith Marr, advertising inquiries to Joyce Crum and address changes to Peg Berry, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517-337-1351.

©1984 Michigan State Medical Society

1866

Returning compliments

We recently received a wonderful note from Doctor Busharat Ahmad regarding our 1984 award from the Sandoz Co. This really surprised and pleased our staff, so we are returning the compliment.

We had planned to send our congratulations much earlier. Unfortunately, (or fortunately for Hutzel's in vitro program) the state's first "test tube" baby was born here soon after we got your letter and that ended all normal activities for a time.

From one editor to another . . . I congratulate you on your fine work. We are constantly reading your magazine to update us on medical issues and to see what members of our staff are doing. You and your staff are doing a great job. In case you haven't seen our magazine, we have enclosed our first four issues.

Pamela Young, Public Affairs
Hutzel Hospital, Detroit

High points

I want to thank you very sincerely for the honor accorded me with the presentation of the Presidential Citation at the opening session of the House of Delegates May 4. As I stated the other night, it came as very much of a surprise, albeit a very welcome one. It was also very nice to have the opportunity to share the presentation with my wife, Suzanne.

Again, my thanks to you and the others at the Michigan State Medical Society who played a part in making the presentation a reality. It certainly is one of the real high points in my professional career.

Hermann A. Ziel, Jr., MD, Chief
Bureau of Health Facilities
Michigan Department
of Public Health
Lansing

AAMA acts

The following resolutions were passed by the 1984 House of Delegates of AAMA, Michigan State Society, during its 34th annual meeting:

Whereas the Michigan State Medical Society has given moral and financial support to this Society and has printed and mailed the handbook for the House of Delgates and the directors; and has granted us the privileges of using their Lansing headquarters for our mailing address and board of directors' meetings, be it RESOLVED: THAT WE EXPRESS OUR SINCERE THANKS.

Whereas, the Michigan State Medical Society has encouraged our society to participate at its Annual Scientific meeting, be it RESOLVED: THAT WE EXPRESS OUR SINCERE THANKS.

We are most appreciative of your continued interest and support of our association, and we are grateful for your presence at our state convention.

Barbara A. Provost
President 1984-1985
AAMA, MSS

MSMS message

Thank you for sending me a copy of the most recent issue of *Michigan Medicine*. I was of course, happy to see that you were able to use the article I submitted for publication. Membership is an issue that is important to both auxiliary members and their physician spouses.

Let me take this opportunity to congratulate you on the excellence of the recent issues of *Michigan Medicine*. I have been particularly impressed with the new layout of the cover and copy. It has added a touch of publication professionalism deserving of the MSMS "message".

I look forward to upcoming publications and again, thank you for remembering me.

Cathie L. Martin (Mrs. David)
MSMS-A Vice President
1984-85
Traverse City

"I've checked your computer, doc, and I'm afraid it's a terminal case . . . !"

Describing how their hospitals handle the delicate issues of the physician-hospital relationship has a *Michigan Medicine* panel deeply absorbed. From left across the table are Robert Black, MD, and James Humes, MD, both of Detroit.

The delicate issues

What is more crucial to the practice of medicine than physicians' relationships with their hospitals? And in what area of medical practice today is more change underway? The many shifts — social, legal and economic — in this crucial relationship were the focus when *Michigan Medicine* gathered four physician experts together June 1 at the Wayne County Medical Society headquarters in Detroit.

The four were Robert Black, MD, chief of staff at Harper-Grace Hospitals, Detroit; Henry Domzalski, MD, Holy Cross Hospital, Detroit, and current secretary of the AMA's Hospital Medical Staff Section; Peter Duhamel, MD, past chief of staff, Crittenton Hospital, Rochester, and 1983 chairman of the AMA's Hospital Medical Staff Section Reference Committee, and James Humes, MD, vice president of medical affairs, St. John Hospital, Detroit.

The purpose was to share their experience and management ideas with their physician colleagues around the state.

Moderator of the discussion was William Madigan, MSMS deputy director and staff to the new MSMS Hospital Medical Staff Section. Mr. Madigan asked the group three questions:

1) How are their hospitals handling granting of privileges in the face of fewer hospitals and more physicians?

2) How are their hospitals handling privileges of non-physician practitioners?

3) How do their hospital boards receive physician input?

The physicians' responses were recorded, transcribed and edited for publication here, and their session photographed. We hope the resulting article proves interesting and helpful to our readers.

We invite MSMS members to respond with their own thoughts and solutions on today's fragile aspects of the physician/hospital relationship.

By Judith Marr, Editor

Mr. Madigan: According to the recent GMENAC study, it is projected that there will be 536,000 physicians by 1990. This same report estimates that only 446,000 will be needed to meet society's requirements. While the actual situation may be less onerous, the trend could make salaried physicians in hospitals, HMOs and universities more attractive to physicians because of guaranteed incomes and benefits. Under these conditions physicians may become more directly competitive in hospitals and members of medical staffs may find competition affecting referral patterns and privileges. Fewer hospitals and more physicians will make a very valuable privilege indeed in the future. How is your hospital handling this problem?

Doctor Humes: This is a problem, and nobody has a very precise way of handling it yet. We have tried to ascertain the impact of a particular physician in an area of practice added to our medical staff, to determine how that one physician will use resources. In

Across the table at the group interview situation at Wayne County Medical Society headquarters were, from left, William Madigan, Lansing, moderator; Peter Duhamel, MD, Rochester, and Henry Domzalski, MD, Detroit.

other words, if you're thinking of adding another orthopedic surgeon, how many beds does the average orthopedic surgeon require and for how long a period of time are his patients hospitalized?

The problem is going to be to match the physicians by numbers and specialties with the resources. The resources of any hospital, whatever its size, are relatively limited, and the number of physicians who can practice in such an institution and have enough activity to keep up their skills is finite. This has not been, to my knowledge, well worked out across the country.

A couple years ago we made a pass at this by doing some relatively simple mathematics. We came up with the impact of an orthopod or a urologist or a family doctor on the hospital resources. And I think that's what hospitals are going to have to do.

I hope we don't come up with a national plan that says we have X number of beds; and this is what the staffing pattern ought to be at our hospital. People practice in different manners in different parts of the country, the patients they serve vary from one community to another, and so forth.

But I think to be able to fend off litigation which may arise and to do justice to the physicians who are applying, you're going to have to have a reasonably well thought out table of organization, if you will. I hate to go back — it sounds like a military way of doing business — but we're going to have to have some grid against which we match the applicants.

Doctor Duhamel: In our situation, with our suburban hospital, we have carried on more of a marketplace philosophy, not necessarily taking all comers on the staff. We screen them out with the usual credentialling process and try to get really good, top quality applicants on the medical staff.

We have applied on several occasions to our board of trustees to close a particular department or group in the hospital, but the board has chosen not to. I think their philosophy is that they wish to avoid litigation, and this is a predicament.

The physicians feel that we're getting too many people on the hospital staff, and that therefore there's a diluting of the hospital facilities available for them to use. There are only so many patients in our service area, and the more physicians we have, the more diluting there's going to be.

There's some feeling, and I think some substantiation, that when you get more physicians in a particular specialty in a particular area, they are going to find work to do. Sometimes it's possible that they might be doing work without indications that are really acceptable. Perhaps some people are going to be doing procedures that may not really have to be done, simply because they have to do work to stay alive economically. We hope that doesn't happen, but this certainly is one of the trends that you might watch for with the increasing supply of physicians in this area.

Mr. Madigan: What are you

doing with present applicants, Doctor Domzalski?

Doctor Domzalski: I'm active at two urban community hospitals, Holy Cross and Saratoga. We have the same concerns that have been expressed by Doctor Humes and Doctor Duhamel. We also have the situation today of declining occupancy. We have established moratoria in cardiology, urology and gastroenterology.

However, with the declining occupancy rates, the administration and the boards of trustees are ever more reluctant to continue with such moratoria. They are more willing to increase the number of physicians on the staff, in the event that may bring a case or two or three to the hospital.

Mr. Madigan: What about multiple appointments? Are there movements to discourage them, say by proximity and specialty, or do you care?

Doctor Humes: We revised our by-laws within the last year, and for the first time stipulated that the physician must have office and/or residence a reasonable distance from the hospital. We didn't measure that in miles, because what's reasonable for a psychiatrist might not be reasonable for a trauma surgeon, and so forth. We've included that kind of language because we feel the physicians have to support the emergency room, have to be available to attend to in-house emergencies and so forth.

Mr. Madigan: You also had to impose moratoria at one time.

Doctor Humes: We have at St. Johns in certain specialties because we have been running at between 100 and 104 percent occupancy of our medical surgical beds. It makes little sense to add physicians in some of those specialized areas when, as Doctor Domzalski says, you have a significant number in one specialty or another. That, then, very much limits the ability of the physicians already there to properly care for the patients in their practice. And that, you know, is a two-edged sword.

In the past few months, however, as Doctor Domzalski mentioned, we have had occasional empty beds in our institution, which is very unusual for us. It's true of most of the major hospitals in southeast Michigan as far as I know.

Doctor Duhamel: We're having some empty beds, too. Just in the last few weeks, we've had a surprisingly low census, in the neighborhood of 50 to 60 percent. It's almost like Christmastime. And nobody seems to know exactly why.

Doctor Domzalski

The economy is going better now than it was in the last three or four years. People are not losing their hospitalization insurance as previously. The administration and the board of trustees are very concerned about this lack of beds, and I think that there will not be any moratoria in the near future until we fill up again.

Doctor Humes: We're all wondering what's happening, to what extend HMOs and PPOs may have made a significant impact.

But you know, when you start thinking about it, there are things that have happened scientifically that have changed this. I'm a pathologist and tuned in to what's coming from the operating room in the way of surgical specimens. A number of years ago there was hardly a day went by that there wasn't an operation for peptic ulcer disease. We basically don't see it because of the medical treatment for peptic ulcer.

Thyroid disease, thyroid nodules, we used to have frequently. Now, with better diagnostic techniques, with needle biopsy of thyroid nodules, there's a marked decrease in surgery. There are many changes of that nature. Medicine and the way it's practiced are changing by scientific advancement.

Mr. Madigan: Does Harper-Grace have a moratorium on hospital privileges?

Doctor Black: We've decided not to declare a moratorium at the present time. We think we have enough flexibility that we need not do that. Within the last three years we have been developing manpower budgets on an annual basis for each department and each specialty.

Mr. Madigan: What are manpower budgets?

Doctor Black: We look at the medical staff and try to determine how a balance can be maintained, geographically, in specialties and also in the general fields.

We believe it's appropriate to look at the ages of the medical staff, at when physicians will begin to retire, and at when we need to bring on younger physicians so those balances can be sustained.

Unfortunately, as we all know, many times staffs have stayed frozen anywhere from five to 20 years, and suddenly there are large voids that have to be filled. Those voids continue and cannot be made up. We're attempting to establish a method that will not allow those voids to occur and also not allow the hospital to be over-loaded with physicians.

We feel the physicians who are on staff have certain prerogatives and rights and that bringing on too many in any one area could be overly competitive. Therefore, when we look at a manpower budget, we're determining what physicians are going to retire or leave the state or do something else in the next year, what physicians and how many we need to bring on to sustain a balance, or build up a specialty, if need be.

Mr. Madigan: Doctor Humes?

Doctor Humes: I think Doctor Black and his associates are trying to do the same thing that we have been trying to do.

We've looked at various specialties, ascertained what the impact of an additional orthopod was by bed, length of stay and so forth, to try to keep those kinds of balances.

His comments reminded me that in every department we look each year at the number of physicians reaching age 65. We have no intention of telling them to retire. But we declare an opening in that department for each person that's 65. It's just a matter of planning and trying to have a reasonable distribution by age.

Doctor Black

Doctor Black: I think that's quite appropriate, Jim. No matter how they perceive their own practices, around age 55 physicians' practices begin to decline. They're not handling the volume of the acute hospital work that they were 10 years previously. You have to begin to supplant with physicians who will pick up that deficit in the number of admissions.

I guess we don't talk about it in this language, but it's a personnel problem. It's a human resources problem. Physicians prefer to imagine that they're somewhat different from any other group. But actually when you begin to analyze how you maintain information on physicians, you understand the personnel or human resources aspects of the situation.

As Jim Humes mentioned, what a physician does within the hospital — the number of admissions, the number of patients and days that he or she will use — is just like any other personnel information. If you begin to work at it from that direction, sustaining a balanced staff becomes a lot more realistic, based less on some mythology of how a medical staff does occur.

Doctor Domzalski: I'd like to ask Doctor Black a question. All this manpower planning and analysis of how health care is delivered in various fields in the hospital is well and good today, if you have a high occupancy. If your occupancy rate plunges to 50, 55 or 60 percent, what happens then?

Doctor Black: I can't give you a response for a large group of physicians on this, Henry, and you know that. But I'll give you my own personal point of view; you should still sustain that type of planning and budgeting. I think that at the sophisticated level at which we're delivering medicine now, the fact that a physician can bring us 150 patients is not the final criteria for why you take that physician on staff. There may be hospital pressures or financial pressures to encourage it, but I don't think that needs to be the reason.

Doctor Domzalski: I'm making the assumption that the physician who applies would be fully qualified and would pass any credentialling process in effect. I'm not talking about admitting a physician on a hospital just to have a body bringing in patients. In that situation, what happens to plans such as you have mentioned?

Doctor Black: I think you have to look at that not only on an annual basis, but also on the basis of whatever strategic planning or five year plan or other projections you're making for your hospital and medical staff. You may want to contract your hospital. You may want to come down from 300 beds to 200 or 225 to continue to sustain a relationship on the staff. Or you may not — the decision may not be just to fill the beds. You may readjust the number of beds and, at the same time, do something else to those beds.

Mr. Madigan: What is your hospital doing to evaluate non-physician practitioners? Doctor Humes?

Doctor Humes? The number of non-physician practitioners in our institution is relatively limited. We have podiatrists, we have psychologists, we have nurse anesthetists as deliverers of health care. They are credentialled in the same manner as all other applicants to the staff. Their annual review is conducted by the department in which they're functioning, and we don't think it's a big burden or a great difficulty.

We don't have any physicians assistants but if we were to they would be assigned to a specific department. The chairman of that department and that department's credential committee would be responsible for monitoring their activities, as well as the physicians who are in those several departments.

Mr. Madigan: Who does the workup, the entering physical for the patient?

Doctor Duhamel

Doctor Humes: Mostly house staff, and in some cases the attending physicians, because of course we don't have enough house staff to cover all the attending physicians.

Doctor Duhamel: Do these non-physicians have admitting privileges?

Doctor Humes: None.

Doctor Domzalski: We have physicians assistants who function under a sponsoring physician and they are well monitored. We have nurse anesthetists and we have psychologists.

Currently, a podiatrist is requesting a tremendous expansion of privileges over what our bylaws permit. He also is requesting admitting privileges. If we elect to allow him to admit patients, he would have to be the co-admittor, and do the history and physical.

The entire responsibility now is with the individual hospital board. Now is the time to be sure that we do have some privileges possible for this individual, and also to insure that a physician is in charge of the medical care. But how you can delineate or how you can limit what an individual does who is licensed by the state and insists he can do procedures in this institution? To me, that's the crux of the problem, how we're going to handle that. Maybe Doctor Black can help me on that.

Doctor Black: We take the position that the hospital, the board of trustees and the medical staff have the responsibility of deciding what privileges can be awarded to any specialist or any physician or any physician extender. We'll so specify and delineate them and feel relatively comfortable in taking that position. Not, Henry, that we won't possibly be challenged; but that's the position we're taking.

We have done that with all physician extenders, whether they be physicians assistants in hospital, attached to a private physician, or whether they be psychologists or whatever. And we've taken the position that none of our physician extenders will admit, but they will have privileges in the hospital for specific reasons.

Mr. Madigan: And in specific departments? Podiatrists in orthopedics?

Doctor Domzalski: When podiatry comes under orthopedics, yes.

Doctor Duhamel: Will they be able to write orders on patients?

Doctor Black: We've defined that so that they can. Our physician extenders, our physician assistants and nurse clinicians certainly write orders. We allow our podiatrists to write orders within those specified privileges which are very specific — no major surgical procedures — for the care of the foot.

Mr. Madigan: Doctor Duhamel?

Doctor Humes

Doctor Duhamel: One class of non-physician that we haven't brought up that has kind of a unique position is the oral surgeon. They've always been considered equal with physicians in all of the hospital bylaws and situations. As you know, we had quite a discussion at the recent House of Delegates meeting about a current bill before the Legislature to formally give oral surgeons the privileges which they are already enjoying, although the new health code does not specify them.

Do you have any problem with treating oral surgeons equally to physicians? If we do, does this open the door for getting podiatrists and psychologists and everybody else through the same loophole?

Doctor Black: Again, I've got to come back to the premise, Peter. What we have done, and felt comfortable with, is decide what the privileges would be for any specialist or any physician extender or any other practitioner in the hospital. We have recommended these guidelines to the board and they've approved them.

For example, we allow oral surgeons to admit, but we require a history and physical examination outside of oral surgery to be done by a physician.

Doctor Domzalski: We have four oral surgeons on the staff, and two have history and physical privileges and two do not. The older ones do not wish them, feel they have not been trained. The younger oral surgeons have gone through residencies and feel they are qualified, and they do have such privileges.

Mr. Madigan: A recent MSMS poll of the 238 Michigan hospitals showed that 83 percent of hospitals had physicians on their boards of trustees. How does your hospital board receive medical input?

Doctor Humes: I have been vice president for medical affairs for 16 years in our hospital, and ever since I've been in that role, we've had physicians on the board of trustees. The elected president of the medical staff serves on the board. I serve on the board. The president elect attends board meetings without a vote. And then we have always had one or more additional physicians who are appointed to the board who are not selected by the medical staff. So we've had good input, I think, for many years.

There's been some discussion as recently as in the last month that our medical staff executive committee ought to recommend to the board of trustees that expansion of physician membership be considered.

But equally important to me and to the physicians on the board is that, for many years, we have enjoyed routinely having physicians on board committees and board members, non-physicians, on medical staff committees. It's amazing the communications that go both ways.

The other thing that we have just recently done is establish a professional relations committee of the board. It will have equal numbers of board members and medical staff members, with the medical staff members chosen by election. We look forward very much to this committee because it will provide some non-physician board members with a better feel for the credentialling and other problems that the medical staff is struggling with. I think it will give a point of entry for more medical staff members' concerns to the board of trustees. I think these things are all very very important.

Doctor Domzalski: I agree with you. This is a resurrection of the old joint conference committee, but in a new form.

Doctor Humes: In a new form, and more forceful.

Mr. Madigan: What is Crittenton Hospital doing with representation on the board?

Doctor Duhamel: Our chief of staff and our medical director sit on the board. In addition we have an active joint conference committee elected by the staff that is composed of five physicians and five members of the board. They audit all of the quality review committee reports. Everything from the executive committee and the medical staff goes through the joint conference committee before it comes to the board. The committee does almost all of the work of the board as it pertains to the medical staff.

Doctor Black: For 10 years we have had representation of physicians by ex officio positions on the board of trustees. There are four, and all of those are elected by the medical staff; our chief of staff, our two vice chiefs of staff from our two divisions, and a fourth ex officio position that is elected out of our medical board, which is the same as an executive committee. And those are four ex officio slots with vote on the board of trustees. We feel that's a reasonable number to represent the interests of the medical staff.

Doctor Domzalski: At our hospital the president of the medical staff is automatically on the board by virtue of office, ex officio, and without vote. The medical director is a full member of the board without vote, and there are two physicians of the community who happen to be staff members.

Doctor Black: I'd like to say one more thing. We're beginning to see holding companies with boards over hospital boards. I think it's very important that there be ex officio slots with votes for physicians on those holding company boards, so we do not lose physician representation.

Doctor Duhamel: Also, there are some hospitals in this area which have hospital-appointed chairmen of departments, and chiefs of staff. There is absolutely no representation by the staff members at large at any level of the hospital governing body. These men who are employed by the hospital do not necessarily have the same point of view as the person who is trying to make a living practicing medicine or surgery. And as a result, also, there is very little in the way of due process in the bylaws of these hospitals.

Doctor Black: We have a major commitment to the university and other major commitments that require fulltime people as departmental chiefs. These are fulltime jobs. A physician in practice just does not have the time or capacity to sustain those types of responsibilities.

Recognizing that, and also that a majority of them also are chairmen at the university, we still have an annual appointment process at the board level or by administrative management. This process goes on annually to determine whether or not those positions should be sustained.

On that basis we feel that the medical staff has a reasonable input, and if some one particular physician is not sustaining the needs of the staff of the department, that would be discussed seriously and brought to the board's attention.

Mr. Madigan: The JCAH, I believe, has due process requirements for physicians. Are there problems with those requirements, and how does your hospital deal with them?

Doctor Humes: Well, everything's a problem. (laughter all around) But again we have revised our bylaws recently according to some suggestions of the JCAH. We now have a demanding and elaborate due process system which will be complicated if we have to put it into effect.

The responsibility really rests in my office for acting in accordance with the bylaws of the medical staff. I'm not a very compulsive person under normal circumstances, but in this area of due process I am super compulsive. We give any physician who feels aggrieved every opportunity to have the grievance heard.

I think the pagination expanded in the bylaws from about a page and a half to about 18 pages under the new system. And it's not of our device. We worked with legal counsel, followed the joint commission's recommendation and reviewed several other bylaws to come up with this very elaborate system.

I don't mean to say that I don't think it's proper. I think it definitely is proper. I think it's going to be somewhat cumbersome; but nonetheless, we'll live with it.

Doctor Domzalski: I agree with Doctor Humes entirely. I think this is the one aspect of hospital staff functioning where prevention is the answer to the situation. If credentialling and reappointment are done in a reasonable manner and done diligently, you prevent problems before they occur.

We have gone through a full review process twice that I've been involved with. As Doctor Humes says, they're extremely cumbersome, and expensive. It cost $20,000 for legal fees that I know of in one instance to go through the complete procedure. So whatever can be done before-

continued on page 335

By Monte D. Jahnke

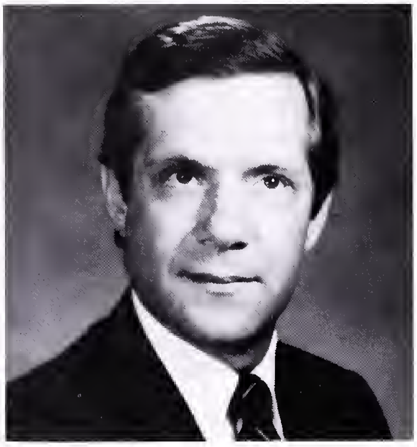
Channeled coverage for liability new hospital/physician development

Few post-World War II economic and social phenomena have occurred so rapidly and pervasively as recent changes in the health care delivery process. The experiences of physicians and hospitals statewide demonstrate this severe national displacement of health care structures. The combined forces of health care, effective cost containment, population stagnation, government belt tightening, and an oversupply of physicians have resulted in one pervasive force: competition.

Michigan physicians' and hospitals' desires to preserve patient loads and to take advantage of emerging patient markets have yielded varying degrees of physician and hospital cooperation or friction. Just how decisions on budgeting, physician and hospital cost accounting, marketing, and delivery systems design ultimately will affect the medical art all remain to be seen.

My guess is that, like the results of recent competition on the auto industry, there will emerge a leaner, perhaps more diversified and market-specific, process of delivering care.

This article discusses a few of the major forces at play nationally and in Michigan. I hope it will also provide some preliminary guidance to concerned physician groups and their hospitals.


Mr. Jahnke

Alternative systems

Displacement of the traditional third-party payor system in Michigan is best exemplified by the explosive growth in alternative delivery systems or sub-systems (ADS). Even the Michigan legislature is involved with a package of new bills to promote provider contracting. Overlapping concepts, confusion, and a tendency to react, rather than act rationally but expeditiously, are symptoms of the increasing fluidity and competition of Michigan health care markets. While the urgency is real, cooler heads are prevailing. They are rejecting forces which would prey upon physician fears.

The rush to preserve or acquire patient loads for physician staffs and overbedded hospitals is complicated. Staffs and institutions which heretofore coexisted peacefully now must cooperate at substantive levels never before demanded. They are finding that with each promised patient load and guaranteed payment come varying forms of utilization protocols, review mechanisms, referral restrictions, and risk sharing formulae. The pertinent legal contracting issues are legion, and include significant antitrust and professional liability concerns.

The most fertile ground for physician/hospital dispute, or cooperation, exists where the ADS arrangement involves a perceived service unit composed of the hospital and all or a portion of the medical staff. This arguably promotes efficiency. How the two will share responsibility for delivering health care through the ADS at or under "budget" has suddenly become a primary question.

For example, both doctors and hospitals probably would agree that physicians would best be suited to develop and enforce ADS utilization, treatment, and referral protocols. If done successfully, however, these activities curtail hospitalization levels and potentially reduce hospital income from the ADS population served. The answer, at least partly, is a larger patient population. Yet no ADS supplier in Michigan currently may be able to deliver such numbers.

The result is that many groups of physicians (with or without their principal hospital) are attempting to contract with as many sources as possible. Though some hospitals cooperate and even lead, those that are mired by bureaucratic inertia or low levels of market sophistication, no doubt damage the competitive potential of their physicians and survival of the institutions.

Mr. Jahnke is a partner in the law firm of Kerr, Russell and Weber. The firm is counsel to MSMS, MPMLC, PROM, and several other health care interests. His practice emphasizes health care and insurance issues, and includes service to many physicians, medical staffs, and physician organizations.

Diligent physicians across the state are rapidly awakening even the most medieval hospital administrations to the necessary tasks at hand.

Hospitals and physicians essentially have two choices: (1) cooperate to face the competition or, (2) fragment and fight it out.

Prospective payment

Governmentally-mandated prospective reimbursement through Medicare DRGs signals a fundamental challenge to physicians and hospitals. Non-Medicare practitioners too soon will be affected, as private payors and Medicaid are moving rapidly in this direction for all aspects of patient service.

Many Michigan hospital staffs and institutions are experiencing DRG "culture shock." Business systems to track physician and hospital DRG cost effectiveness are being implemented which could precipitate much friction. The systems are necessary, but must be designed and used equitably to assure balance between quality care, and the legal rights of all involved.

Armed with behavioral facts, the institutions may turn to medical staff credentialling committees to restrict or deny future privileges to certain practitioners. Hospitals also will begin to know which types of treatment or "lines of business" they can perform most profitably under DRGs. Elimination or limitation of departments, and admission limits could occur out of economic necessity.

Medical records become the touchstone of reimbursement determination under DRGs. Physicians can expect more stringent recordkeeping demands from hospitals. Like other DRG results, they could affect directly physician practice styles, the level of care, reimbursement levels, and overall staff concerns.

Medical staffs should give close attention to DRG implementation; hospitals and staffs must develop informed dialogues to survive under the new federal law or any DRG or other prospective payment system.

Liability Insurance

An alluring phenomenon is emerging in physician professional liability. It involves hospital-specific liability coverage for physicians, is available through a hospital, and covers physician exposures occurring only at the hospital.

The insurance industry calls this channelled coverage. While attractive in concept and cost, it has some Michigan practitioners concerned. Such unified coverage could give control of later litigation to a co-defendant hospital which was the purchasing or procuring source of the insurance. Potentially conflicting hospital/physician litigation interests could be overlooked by an insurer eager to curtail overall loss adjustment expenses. Physicians offered such plans should satisfy themselves that their own rights will be protected and considered.

Physicians also are concerned about non-hospital occurrences unaddressed by a channelled program. Beyond the price for such wrap-around insurance and its availability from reputable carriers, are concerns of overlapping or disputed coverage where an injured patient has been seen in and out of the hospital. Liability alleged encompasses both settings.

Channelled programs in Michigan are new. Physicians may find them beneficial, but must understand them fully before accepting a hospital's offer. Insurance, like many other products, is often as good as the amount paid for it.

Alternative systems and competition, prospective payment, and insurance concerns are only three broad gauntlets now cast before physicians in our state. They require innovative responses, skillful legal assistance, and short range action geared to long range solutions.

My advice: Act, don't react; Plan, don't turn away. As before, I am sure MSMS members and other forward-thinking physicians will meet these challenges.

DELICATE/continued

hand is to our advantage. We all have this long, cumbersome process in our bylaws.

Mr. Madigan: Does anybody want to add anything to that?

Doctor Duhamel: Well, as you probably are aware, there are a large number of us in the Rochester/Pontiac area who have been in the process of being sued for the last eight years over a loss of privileges for one of the surgeons. That case has not come to court. I don't know if it ever will. However, the problem is that since that suit was initiated, it has been difficult to get anybody to serve on any kind of hearing committee for any of the hospitals in our area. They say they could be sued, and I have no good answer to that.

Doctor Black: I hope that all the hospitals here indemnify their physicians for all their responsibilities.

Doctor Duhamel: As a matter of fact, we had to take the hospital in question into court to get it to agree to indemnify the physicians involved in this suit.

Doctor Black: I think it's important that up front all hospital administrations or boards should idemnify all their physicians for any possible administrative professional review responsibilities. That should be a commitment up front by every board of trustees with their medical staffs.

Doctor Humes: I think if we give no other message to all physicians practicing in hospitals in this state, we should stress that this is crucial and absolutely essential.

By William E. Madigan

New MSMS Medical Staff Section to address the issues

> **"To provide a forum for hospital medical staffs to discuss common issues and concerns . . . "**

The MSMS Board of Directors and the Medical Staff Relations Committee have been working over the past year to strengthen the ties between hospital medical staffs and hospital administrations. Their activities have culminated in the formation of the MSMS Hospital Medical Staff Section, which was formally approved at the 1984 MSMS House of Delegates meeting. The new section is an MSMS response to changes in the medical care environment which will increase the need for representation of medical staffs in the formation, development and implementation of new policies in the area of physician/hospital relationships.

The MSMS Hospital Medical Staff Section has a structure similar to that of the AMA Hospital Medical Staff Section. One HMSS delegate and one alternate delegate have a seat in the MSMS House of Delegates.

A governing council directs the progress and activities of the Section. This council consists of a chairman, vice-chairman, secretary, two at-large members, plus one delegate and alternate delegate to the House of Delegates.

Representatives to the Hospital Medical Staff Section are members of MSMS and the AMA. They shall be nominated and elected by the active voting physician members of each medical staff of JCAH accredited hospitals in Michigan. They must have clinical privileges at the institution they represent. Medical staffs should, whenever possible, elect the same representative to this position as is elected to the AMA Hospital Medical Staff Section.

The Section is organized as an open assembly to which each hospital medical staff of JCAH accredited hospitals in Michigan is eligible to send one elected representative.

The Section will meet at least 40 days prior to the MSMS House of Delegates.

3C
H
H
H
HOSPITAL
HOSPITAL
HOSPITAL
REG HIDER

"Don't they make a great team?"

MSMS has formed its Hospital Medical Staff Section with the following goals in mind: (1) To provide a forum for hospital medical staffs to discuss common issues and concerns; (2) To increase awareness of and to communicate on issues affecting physicians as members of hospital medical staffs; (3) To increase two-way communication between MSMS and hospital medical staffs and (4) To provide access into the policy-making body of MSMS.

The following premises are integral foundations of the new section's operation: (1) The hospital medical staff representative should be someone who could acquire experience and provide continuity of representation for a period of years; (2) The hospital medical staff representative should be someone other than a current AMA delegate or alternate delegate; (3) A mechanism should be established whereby the representative of the hospital medical staff regularly communicates with the hospital medical staff and the governing body of the hospital, and (4) The hospital medical staff representative should communicate on a regular basis with his/her component medical society.

The MSMS Board of Directors and the Medical Staff Relations Committee believe that issues and problems unique to hospital medical staffs will be effectively addressed through the new Hospital Medical Staff Section.

Mr. Madigan, of East Lansing, is MSMS deputy director and staffs the new MSMS Hospital Medical Staff Section.

BROWN **THE BROWN PHARMACEUTICAL CO., INC.**
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android®/5 mg. Buccal/10 mg. Oral/25 mg. Oral
Methyltestosterone U.S.P. Tablets

ANDROID®/F
Fluoxymesterone U.S.P. Tablets, 10 mg.

Auxiliary has share in providing quality medical care

The following article is taken from the address delivered in May by Mrs. Crandall as she was installed as president of the MSMS Auxiliary. She follows her husband, Donald K. Crandall, MD, into top office of their respective medical organizations. Doctor Crandall, a general surgeon, served as MSMS president from May, 1983, to May, 1984. Mrs. Crandall is an RN, a certified fitness instructor, member of the West Michigan Shoreline Regional Planning Commission and of the Norton Shores City Council. She is past president of the Muskegon County Medical Society Auxiliary, has served on the MSMS Auxiliary Board since 1977, and also serves on the Michigan Health Council. She has been active in Planned Parenthood, YFCA, League of Women Voters, NOW, AAUW, PEO and the Methodist Church. She and Doctor Crandall, Muskegon-area residents, are the parents of three sons.

Mrs. Nancy Crandall
MSMS/A President, 1984-85

I feel we need to examine during the next year our auxiliary's relationships with MSMS.

Our bylaws state that the purposes of this auxiliary shall be educational and charitable. They shall be to assist in those programs of the Michigan State Medical Society that advance medicine and health education; to uphold the programs of the American Medical Association Auxiliary, and to coordinate and advise concerning the activities of county auxiliaries.

We are spouses of physicians, male and female, and as such we have a share in the responsibility of protecting and improving public health and of assisting physicians in providing quality medical care.

This is "who" we are.

We should be working with the medical society, both through our organization's activities and by contributing when we can on MSMS committees and on our own county society committees.

We have several Auxilians currently serving on MSMS committees and there will be additional appointments. Because of a close relationship (developed over many years) with the current MSMS leadership, steps are being taken to strengthen the partnership and improve communication. We do have an obligation individually however, to become better educated about health issues, about current legislation impacting health care and about any other areas in which we can be of assistance to medicine in American today.

One thing we all can do to further our education is to read the monthly *Michigan Medicine* and *Medigram* news publications of MSMS. These two publications most often are sent to individual physicians' offices. If that is the case with your spouse, please ask him or her to bring issues home and then avail yourself of the information they provide.

Our organization, since its founding in 1926, has been growing and developing, just as people grow and develop throughout life. And just as with people, the organization needs to take stock of that growth from time to time, to see where it is headed and what has been accomplished, and to evaluate its development.

Let us look together at who we are, what our purpose is, what our goals are and how we can best achieve them. I would like for us to focus in the coming year on our Auxiliary, and to concern ourselves with its growth and development.

There are so many ways we can contribute to society today, and we have so many capable people. I hope that the MSMS Auxiliary provides the means and support for you and your physician spouses to contribute in your communities and in the state of Michigan.

Michigan and medicine do need our help.

OBESITY.

THE CONSEQUENCES CAN BE LIFE-SHORTENING.

As physicians, every one of us knows the consequences of obesity: cardiovascular disease. . . diabetes. . . hypertension. . . congestive heart failure. . . an increased risk of sudden death.

Most of us also recognize how difficult it is for the obese patient to lose weight, not to mention the frustrations and failures that attend long-term maintenance of normal weight.

The Institute for Health Maintenance (IHM) can help.
Working in conjunction with a patient's primary care physician, IHM offers a medically sound regimen for therapeutic weight loss: THE RISK FACTOR OBESITY PROGRAM (RFO).

Developed under clinical conditions at major medical teaching institutions, the RFO Program combines a medically supervised supplemented fast with long-term behavioral and nutritional training.

Under the supervision of physicians and their staff, patients lose weight safely and consistently over a period of weeks and months, receiving their total daily nutritional requirements from a low-calorie egg albumen formulation supplemented with potassium and vitamins.

The success of the RFO Program has been significant.
Over the past five years, more than ten thousand patients have lost from 25 to over 400 pounds, with an average weight loss of 63 pounds. More important, 50% of patients admitted to our program have been able to sustain their new low weight levels for one year with the help of long-term maintenance.

Some patients have called the RFO Program "life-saving." As physicians, we know the relationship between certain risk factors and longevity. Obesity is one of those factors—one we can help reduce.

To learn more about us and how this program can safely benefit some of your patients, please contact (313) 832-2460.

The Risk Factor Obesity Program
Medically designed. Medically supervised. Medically sound.

MSMS Annual Scientifc Meeting focuses on clinical medicine

The emphasis will be on the art of clinical medicine at the 1984 MSMS Annual Scientific Meeting planned Nov. 13-15 at the Hyatt Regency Dearborn.

"We're really trying to help physicians with their clinical practices," says Chairman David R. Rovner, MD, East Lansing. "We want to help them carry out a more artful practice of medicine."

Annual Scientific Meeting promotional literature this year will carry out the "artful" theme, while bringing home the message that clinical practice is the target.

Surgeons special

Doctor Rovner and the committee are paying special attention to Michigan surgeons as they plan the courses. "We reexamined our list of attendees and saw surgeons are well represented," said Doctor Rovner. "We have beefed up our course offerings for them."

A full list of courses is printed in the June 28 *Medigram* newsletter.

The committee also has made a special effort to attract younger physicians, and others new in the practice of medicine.

"We have worked to develop experiences useful to them," he said, "starting with our first effort to provide poster sessions."

The poster sessions will be presented Wednesday afternoon, Nov. 14, in the exhibit hall. MSMS is working with the Hyatt Regency Dearborn to provide a wine and cheese reception to run concurrently with the poster presentations.

Physicians who are interested in making this kind of a presentation may obtain mechanical and academic requirements from Sherry L. Fent, MSMS Physician Education Coordinator.

Doctor Rovner

"With great verve and care for the future, we are making these changes in our Annual Scientific Meeting," explains Doctor Rovner.

For the first time, the committee has solicited courses from hospitals. In the past, a few have been provided each year, but this time the committee went after the hospitals.

As a result, Oakwood in Dearborn, Beaumont in Royal Oak, Borgess in Kalamazoo, Henry Ford in Detroit, Children's in Detroit, Sinai in Detroit, and the Michigan Headache and Neurological Institute in Ann Arbor all have been recruited to present courses.

Theirs will be in addition to the many always provided by the state's medical schools and interested individual physicians.

As in the past, the meeting will offer 55 half-day Category I CME courses, accompanied by 75 scientific and educational exhibits, luncheons in the exhibit hall and half-hour breaks in the middle of all courses. A total of 18 Category I Credits may be earned.

The Hyatt Regency again will be the setting, with its excellent, easily accessible facilities for many courses running simultaneously, its large exhibition area, separate facilities for course directors and staff, and emergency medical care available.

Ninth meeting

This will be the ninth consecutive annual CME meeting offered by MSMS since the 1976 legislation making continuing medical education mandatory for all practicing physicians.

Each meeting has followed the same basic format and annually attracts close to 2,000 Michigan physicians.

All 1984 courses have been approved and arranged by Doctor Rovner's committee, course directors designated, and each day's lineup established. (The committee begins working on each year's meeting before the previous year is over.)

On the committee are Frederick W. Bryant, MD, Royal Oak; Denis F. Cash, MD, Flint; Edward Cotton, MD, Marcellus; Robert D. Johnson, MD, Grand Rapids; Dorothy Kahkonen, MD, Detroit; Kenneth L. Krabbenhoft, MD, Detroit; Joan C. Stryker, MD, Detroit; and Herbert A. Auer, East Lansing, consultant.

Please watch coming issues of *Michigan Medicine* and *Medigram* for further details, including course and housing registration forms.

EXCLUSIVE

MICHIGAN GAZETTE

TALWIN® Nx...BUILT-IN PROTECTION AGAINST MISUSE BY INJECTION

Major Analgesic Reformulated

Now contains naloxone, a potent narcotic antagonist

Extra security added to proven efficacy and safety

No longer do doctors have to deny patients the benefit of an effective oral analgesic for fear of its misuse by injection.

Winthrop-Breon Laboratories has met a nagging problem by reformulating TALWIN® 50 (pentazocine HCl tablets) with the addition of naloxone, equivalent to 0.5 mg base. The reformulated product is called TALWIN® Nx.

The original formulation had been subject to a form of misuse among street abusers known as "T's and Blues." TALWIN 50 and PBZ,* an antihistamine, would be ground up together, put into solution, and injected intravenously. The combination produced a heroin-like high. Because naloxone is a narcotic antagonist when injected intravenously, it acts to nullify any high a "T's and Blues" addict might expect from the pentazocine in a combination of TALWIN Nx and PBZ. When taken as directed orally, the naloxone component of TALWIN Nx is inactive. Thus, TALWIN Nx continues to be a safe, effective, oral analgesic for the relief of moderate to severe pain, now providing added security against misuse.

*Registered trademark of Ciba-Geigy Corp for tripelennamine.

T-540 NDC 0024-1951-04
100 tablets
CIV
Talwin® Nx
Each tablet contains pentazocine hydrochloride, USP, equivalent to 50 mg base and naloxone hydrochloride, USP, 0.5 mg.
Caution: Federal law prohibits dispensing without prescription.
Winthrop

Talwin® Nx

CIV Each tablet contains pentazocine HCl, USP, equivalent to 50 mg base and naloxone HCl, USP, 0.5 mg.

The reformulation of Talwin 50 to Talwin Nx involved the addition of 0.5 mg naloxone to help prevent misuse by injection.

Winthrop-Breon

© 1984 Winthrop-Breon Laboratories

Please see following page for Brief Summary.

Talwin® Nx ⓘⓥ

Each tablet contains pentazocine HCl, USP, equivalent to
50 mg base and naloxone HCl, USP, 0.5 mg

Analgesic for Oral Use Only

Contraindications: Hypersensitivity to either pentazocine or naloxone

> TALWIN® Nx is intended for oral use only. Severe, potentially lethal, reactions may result from misuse of TALWIN® Nx by injection either alone or in combination with other substances. (See **Drug Abuse and Dependence** section.)

Warnings: *Drug Dependence* Can cause physical and psychological dependence (See **Drug Abuse and Dependence**.) *Head Injury and Increased Intracranial Pressure.* As with other potent analgesics, respiratory depressant effects of the drug may elevate cerebrospinal fluid pressure due to CO_2 retention; these effects may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Can obscure the clinical course of patients with head injuries; in such patients, use with extreme caution and only if deemed essential *Usage with Alcohol.* Due to potential for increased CNS depressant effects, alcohol should be used with caution. *Patients Receiving Narcotics* Pentazocine is a mild narcotic antagonist. Withdrawal symptoms have occurred in patients previously given narcotics, including methadone. *Certain Respiratory Conditions* Should be administered with caution in respiratory depression from any cause, severely limited respiratory reserve, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

Precautions: *CNS Effect* Use cautiously in patients prone to seizures, seizures have occurred though no cause and effect relationship has been established. Therapeutic doses have in rare instances, resulted in hallucinations (usually visual), disorientation, and confusion, which cleared spontaneously within a period of hours. Such patients should be very closely observed and vital signs checked, if the drug is reinstituted, it should be done with caution since the acute CNS manifestations may recur. *Impaired Renal or Hepatic Function* Decreased metabolism of pentazocine in extensive liver disease may predispose to accentuation of side effects, it should be administered with caution in renal or hepatic impairment. In long-term use, precautions should be taken to avoid increases in dose by the patient. *Biliary Surgery.* Some evidence suggests that unlike other narcotics pentazocine causes little or no elevation in biliary tract pressures, the clinical significance of these findings is not yet known. *Information for Patients.* Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards. May cause physical and psychological dependence taken alone and may have additive CNS depressant properties in combination with alcohol or other CNS depressants. *Myocardial Infarction.* Use with caution in patients with myocardial infarction who have nausea or vomiting. *Drug Interactions Usage with Alcohol*: See **Warnings.** *Carcinogenesis, Mutagenesis, Impairment of Fertility* No long-term studies in animals to test for carcinogenesis have been performed. *Pregnancy Category C*: Should be given to pregnant women only if clearly needed. *Labor and Delivery* Use with caution in women delivering premature infants. Effect on mother and fetus, duration of labor or delivery, need for forceps delivery or other intervention or resuscitation of newborn, or later growth, development, and functional maturation of the child is unknown. *Nursing Mothers* Caution should be exercised when administered to a nursing woman. *Pediatric Use* Safety and effectiveness in children below the age of 12 years have not been established.

Adverse Reactions: *Cardiovascular* Hypotension, tachycardia, syncope. *Respiratory* Rarely, respiratory depression. *CNS. Acute CNS Manifestations*: In rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours, may recur if drug is reinstituted. *Other CNS Effects.* Dizziness, lightheadedness, sedation, euphoria, disturbed dreams, hallucinations, irritability, excitement, tinnitus, tremor. *Gastrointestinal*: Nausea, vomiting, constipation, diarrhea, anorexia, rarely abdominal distress. *Allergic*: Edema of the face, dermatitis, including pruritus; flushed skin, including plethora. *Ophthalmic.* Visual blurring and focusing difficulty. *Hematologic*: Depression of white blood cells (especially granulocytes), which is usually reversible, moderate transient eosinophilia. *Other*: Headache, chills, insomnia, weakness, urinary retention.

Drug Abuse and Dependence: *Controlled Substance* TALWIN Nx is a Schedule IV controlled substance.

Dependence and withdrawal symptoms have been reported with orally administered pentazocine. Patients with a history of drug dependence should be under close supervision. Possible abstinence syndromes in newborns after prolonged use of pentazocine during pregnancy have been reported. In prescribing for chronic use, the physician should take precautions to avoid increases in dose by the patient. Tolerance to the analgesic effect is rarely reported; there is no long-term experience with oral use of TALWIN Nx.

The amount of naloxone present (0.5 mg per tablet) has no action when taken orally and will not interfere with the pharmacologic action of pentazocine; however, this amount of naloxone given by injection has profound antagonistic action to narcotic analgesics. TALWIN Nx has a lower potential for parenteral misuse than the previous oral pentazocine formulation, but is still subject to patient misuse and abuse by the oral route.

Severe, even lethal, consequences may result from misuse of tablets by injection either alone or in combination with other substances, such as pulmonary emboli, vascular occlusion, ulceration and abscesses, and withdrawal symptoms in narcotic dependent individuals.

Overdosage: *Treatment* Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated. Assisted or controlled ventilation should also be considered. For respiratory depression, parenteral naloxone (Narcan®, available through Endo Laboratories) is a specific and effective antagonist. *Please consult full product information before prescribing*

Winthrop-Breon
WIN 4-41415B

Winthrop-Breon Laboratories
Division of Sterling Drug Inc.
New York, NY 10016

MSMS and MSMS Auxiliary members at a recent MDPAC/AMPAC political education workshop launched simulated political campaigns. Playing a situation game called "See How They Run," they learned the necessity for organization, image, strategy and data. Plunging into play from left, above, were Winifred Oyen, MD, Midland; Nancy Crandall, Muskegon; Lois Duhamel, Rochester, and Lillian Fields, Parma.

See how they run

Participants in the game were directed by Michael E. Dunn of Washington, DC, an AMPAC consultant, as they earned tokens for preparing "literature," having it printed, producing "spot commercials" and "bios" of their "candidates." At left is Nanci Stone of Muskegon, at right Richard Duff, MD, Rochester.

At lunch during the workshop, Rep. Paul Hillegonds (R-Holland), second from right, emphasized that PACs must not just contribute dollars, but also follow the candidates' careers and help educate legislators. From left, above, are Wayne Bradley, vice president for public affairs, AMA; Kevin Kelly, MDPAC staff; Rep. Hillegonds and Thomas E. Stone, MD, Muskegon, MDPAC chairman.

Competence counts

Hurley Medical Center photo

In selecting a doctor, 74 percent of Americans consider competence, not cost.

Competent doctors remain the key to health. But competence isn't immunity to litigation.

Consider our competence – and our professional liability protection and strong-defense philosophy.

We defend you against non-meritorious claims. We won't settle a claim without your approval or merely to cut our defense cost.

PICOM
Physicians Insurance Company Of Michigan
4277 Okemos Rd., Box 1000
Okemos, Michigan 48864
(517) 349-6500
(313) 557-4845
1-800-292-1036

MDPAC luncheon speaker stresses Michigan economics

By Carole Eberly

Draperies of the elegant old ballroom of the Amway Grand Plaza Hotel in Grand Rapids frame the crowd gathered for the annual luncheon of the Michigan Doctors Political Action Committee. The luncheon was held during the 1984 MSMS House of Delegates meeting there.

The number one problem in Michigan right now is jobs, according to Senate Majority Leader John Engler, R-Mt. Pleasant.

Engler, who spoke at the MSMS House of Delegates MDPAC luncheon in Grand Rapids, said Republicans will be aiming to get Michigan's economy rolling once again.

"Since 1980, we've lost 315,000 population in Michigan," Engler said. "And jobs are our biggest problem."

We've got to encourage Michigan to get back to work," he told MSMS members at the Amway Grand Plaza. "We've got to encourage business to want to stay in Michigan and want to come to Michigan."

He said one encouraging sign is that unemployment dropped from 15.1 percent to 10.6 percent according to the latest government figures.

Positive environment

Engler said Michigan lawmakers and government officials must look at the international market and at foreign competition, not just limit themselves to local or regional concerns.

"What's the future going to be like in Michigan?" he asked. "We want to create a positive environment for entrepreneurs; one the shop owner on Main Street can relate to."

In another area, Engler said Republicans, who took control of the State Senate for the first time in a decade earlier this year, would try to funnel more money into education.

"We've got to reverse the trends going on in education on the K-12 and college levels," he said.

He explained the GOP goal is to shift the burden for funding away from the college student and local taxpayer to the state.

Engler said one thing Republicans did that saved the state money recently was institute a one-week waiting period for workers' unemployment compensation benefits.

"It will save the state $75 million," he said. He added that it won't take away from those unemployed over a long period of time, but would eliminate payments for those who are jobless for only short periods of time.

Engler said he would not discuss in detail the GOP's hopes to roll back the state income tax rate to its former 4.6 percent level next January 1.

"Republicans are against higher taxes," he said. "Look at the record. See how we voted. It's right there in black and white in the Senate and House Journals for public scrutiny."

However, Democratic Rep. Thomas C. Mathieu of Grand Rapids, who also spoke at the luncheon, criticized Republicans for supporting the accelerated rollback. Democrats are calling for a rollback amounting to about a $130 million tax cut, he said, while Republicans' proposals would have a $500 million impact.

"Where will this extra money come from?" asked Mathieu. He predicted much of it would be taken from the public and mental health budgets.

He said the tax increase was to help Michigan regain its credit rating and straighten out its financial house. Mathieu said by moving too fast to roll back the taxes, Michigan could once again be in sad shape.

He predicted that a rollback would result in Medicaid cost-shifting, crippling hospitals that depend heavily on Medicaid patients. In addition, he predicted an increase in bad debts from patients unable to pay.

continued on page 346

Ms. Eberly is a Lansing area freelance writer.

Who needs over a million dollars in professional liability protection?

Very Possibly YOU Do!

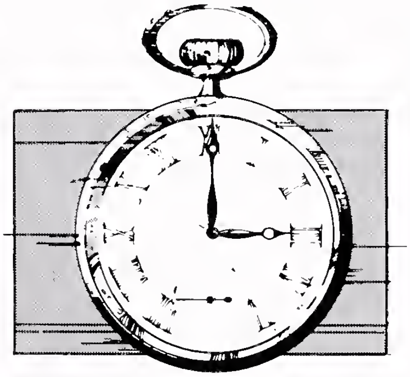
The Michigan lawyers' MILLION DOLLAR CLUB is comprised of attorneys who have won awards over that amount, many from physicians or surgeons who had exercised their very best judgement.

And the jury awards continue to grow.

The Michigan Doctor's Excess Professional Liability Insurance affords...

Protection That Starts When Your Present Policy Stops – And The Jury Keeps Going.

It does not replace your present policy, but it surely supplements it – up to $3 million additional limits.



Now Is The Time To Act!

Changes are effective right now that could be very beneficial to you and your practice. Such as:

- The availability of limits of liability up to **$3,000,000/$3,000,000** excess of $200,000/$600,000 or excess of $1,000,000/$1,000,000;
- A **rate reduction of 10%** for all classes purchasing limits in excess of $200,000/$600,000;
- For P.C.'s, clinics, etc., **discounts up to 50%** for relief or substitute physicians;
- **40-30-30 payment plan** available for annual premiums of $5,000 and above.

For further details about Michigan Doctor's Excess Professional Liability Insurance, please contact HASCO or your insurance agent.

Underwritten by: **PACIFIC EMPLOYERS INSURANCE COMPANY**
Los Angeles, California

Serviced by:
HASCO
P.O. Box 33008
Detroit, Michigan 48232
(313) 567-1955

MSMS Board Chairman Thomas R. Berglund, MD, Portage, left, who also is a member of the American Medical Political Action Committee Board, and 1983-84 MSMS President Donald R. Crandall, MD, Muskegon, right, shared a laugh at the head table with speaker Rep. Thomas C. Mathieu, D-Grand Rapids.

Sen. Engler

He also said the rollback could mean delays in treatment to the chronically ill, the poor and elderly, along with the elimination of such services as dental care, eye care and pharmaceutical benefits. In addition, he predicted a $500 million rollback would mean a decrease or elimination in preventative health measures such as water quality control, hearing and vision screening, and VD testing.

No altar

Mathieu said he did not want to see health care "on the altar of tax cut mania."

"Not only is the physical health of Michigan at stake here, but the economic health, too," he said.

Mathieu, a member of the House Appropriations Committee, said the rollback is the "number one issue facing us today."

"The tax issue has the most wide-ranging effects of any issue before us," he said.

Mathieu said Michigan has been faced with the irony of decreasing revenues, but increasing tax needs.

He said now that Michigan is finally on the right financial track, lawmakers should be careful to keep it moving along.

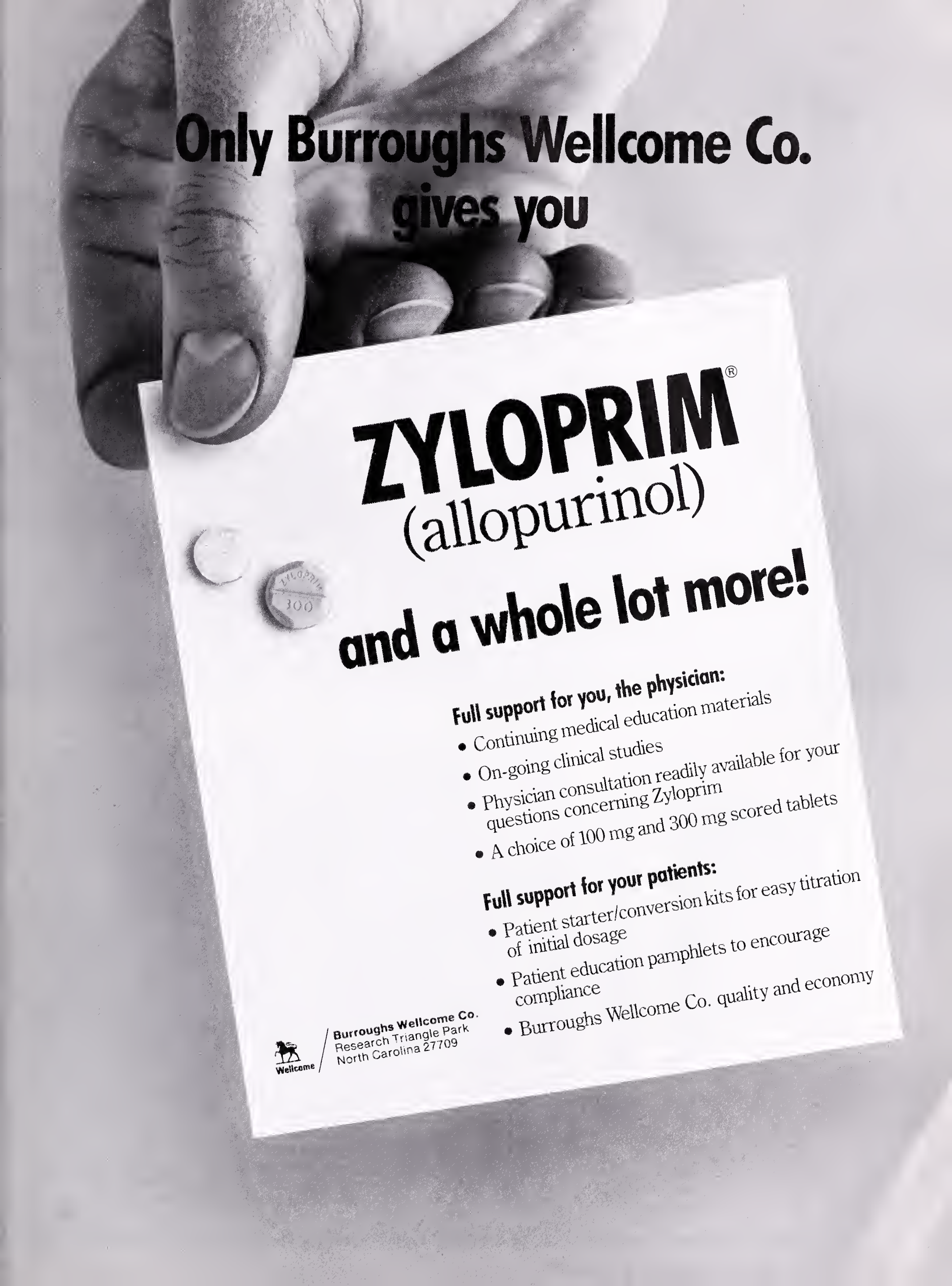
THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

1st FOR PROFESSIONAL PROTECTION EXCLUSIVELY

YOUR FIRST STEP TO FIRST QUALITY PROTECTION
CONTACT FIELD REPRESENTATIVES

Eastern Office
JOHN K. GALLOWAY, THOMAS A. WEISMAN, WAYNE M. BACKUS,
MARK A. TISDEL and CHARLES J. ROWE
6785 Telegraph Road, Suite 350, Birmingham, Michigan 48010
(313) 647-6640

Western Office
GEORGE J. HAWORTH
2600 Five Mile Road, NE, Suite 101
Grand Rapids, Michigan 49505
(616) 361-0863



Only Burroughs Wellcome Co. gives you

ZYLOPRIM®
(allopurinol)

and a whole lot more!

Full support for you, the physician:

- Continuing medical education materials
- On-going clinical studies
- Physician consultation readily available for your questions concerning Zyloprim
- A choice of 100 mg and 300 mg scored tablets

Full support for your patients:

- Patient starter/conversion kits for easy titration of initial dosage
- Patient education pamphlets to encourage compliance
- Burroughs Wellcome Co. quality and economy

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Three hundred physicians elected by their peers concentrated intently on business at the 1984 MSMS House of Delegates meeting and worked hard to determine policy for the state society's next several years. Among them were members of the Genesee County delegation, above, from left, Henry M. Mendrek, MD, and Vivian P. M. Lewis, MD, both of Flint.

MSMS delegates set 1984-85 directions

The highest MSMS awards, Presidential Citations, were presented to two physicians during ceremonies before the delegates. At left, Donald H. Kuiper, MD, Lansing, left, receives the citation from 1983-84 MSMS President Donald K. Crandall, MD, Muskegon. Doctor Kuiper was cited for his years of service as president of the Michigan Board of Medicine. At right, Hermann A. Ziel, MD, Lansing, left, receives the citation from 1984-85 MSMS President Louis R. Zako, MD, Dearborn Heights. Doctor Ziel was honored as he retired as chief of the Health Facilities Services Administration of the Michigan Department of Public Health and for his long-time service to the MSMS Committee on Maternal and Perinatal Health.

Photos
by
Chuck Federowicz
and
Kim Kauffman

The spacious new ballroom of the Amway Grand Plaza Hotel in Grand Rapids provided a dramatic setting for the MSMS annual meeting, with delegates and their activities reflected in mirrored ceiling recesses.

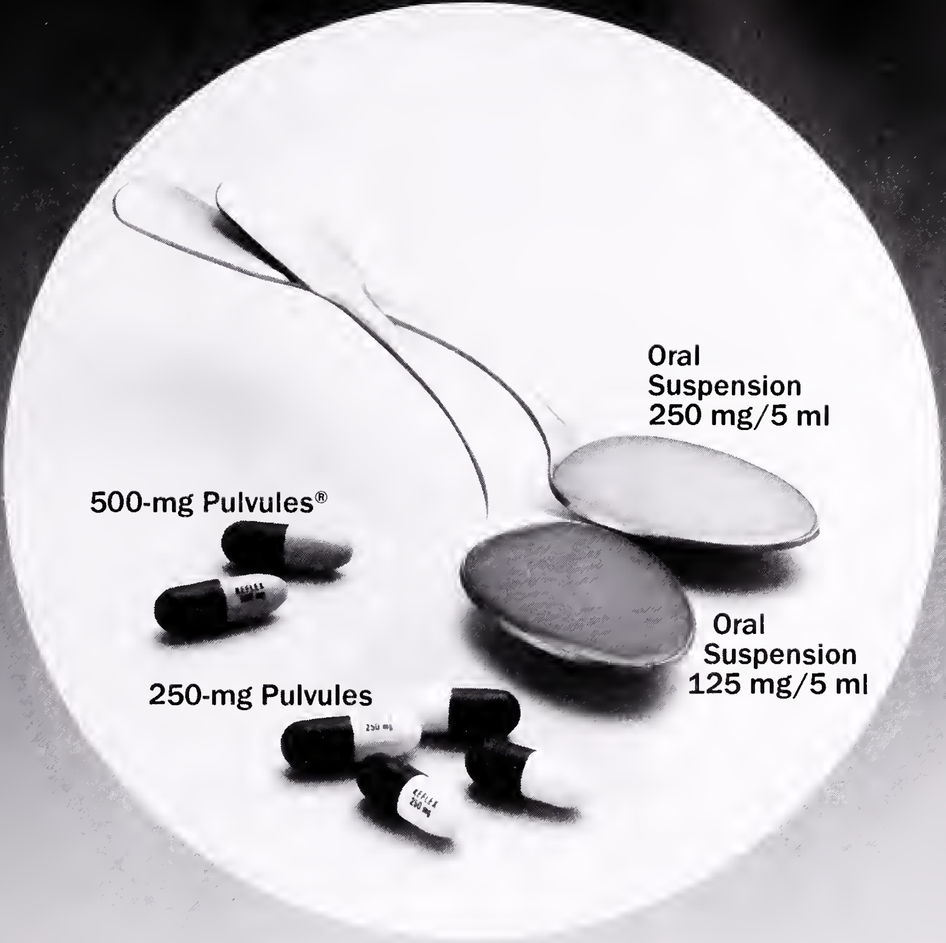
This quartet was photographed as they reported to the delegates on current areas of intense MSMS activity. From left is Frederick W. Van Duyne, MD, Flint, president of the MSMS-founded Physicians Review Organization of Michigan (PROM), which is bidding to become the federally-designated state peer review body; Gary D. Maynard, MD, Kalamazoo, leader of efforts to form the new MSMS Hospital Medical Staff Section; Karl J. Edelman, Ann Arbor, leader of the new MSMS Medical Student Section, and Michael J. Sullivan, MD, Farmington Hills, leader of the new MSMS Resident Physician Section.

Newly-named MSMS president-elect Richard J. McMurray, MD, Flint obstetrician-gynecologist, took a symbolic walk to the front of the delegate body to address the group. Behind him on the rostrum were, from left, Richard Weber, Detroit, MSMS legal counsel; Vice Speaker Robert D. Burton, MD, Grand Rapids, and Speaker of the House Gerald H.. Mandell, MD, Detroit.

Approximately 30 MSMS members who graduated 50 years ago from medical school received gold pins and the delegates' acclamation for their years of service. Before their recognition in front of the delegate body, Mrs. Ruth Gutow made last minute touches to tie of husband Benjamin R. Gutow, MD, Sterling Heights.

Retiring MSMS board members Busharat Ahmad, MD, Marquette, left, and James H. Tisdel, MD, Port Huron, right, were recognized by the board, led by Chairman Thomas R. Berglund, MD, Portage, center. Doctor Ahmad also served three years as chairman of the Publications Committee, while Doctor Tisdel is past MSMS president and Publications Committee chairman.

Easy To Take


Oral
Suspension
250 mg/5 ml
500-mg Pulvules®
Oral
Suspension
125 mg/5 ml
250-mg Pulvules

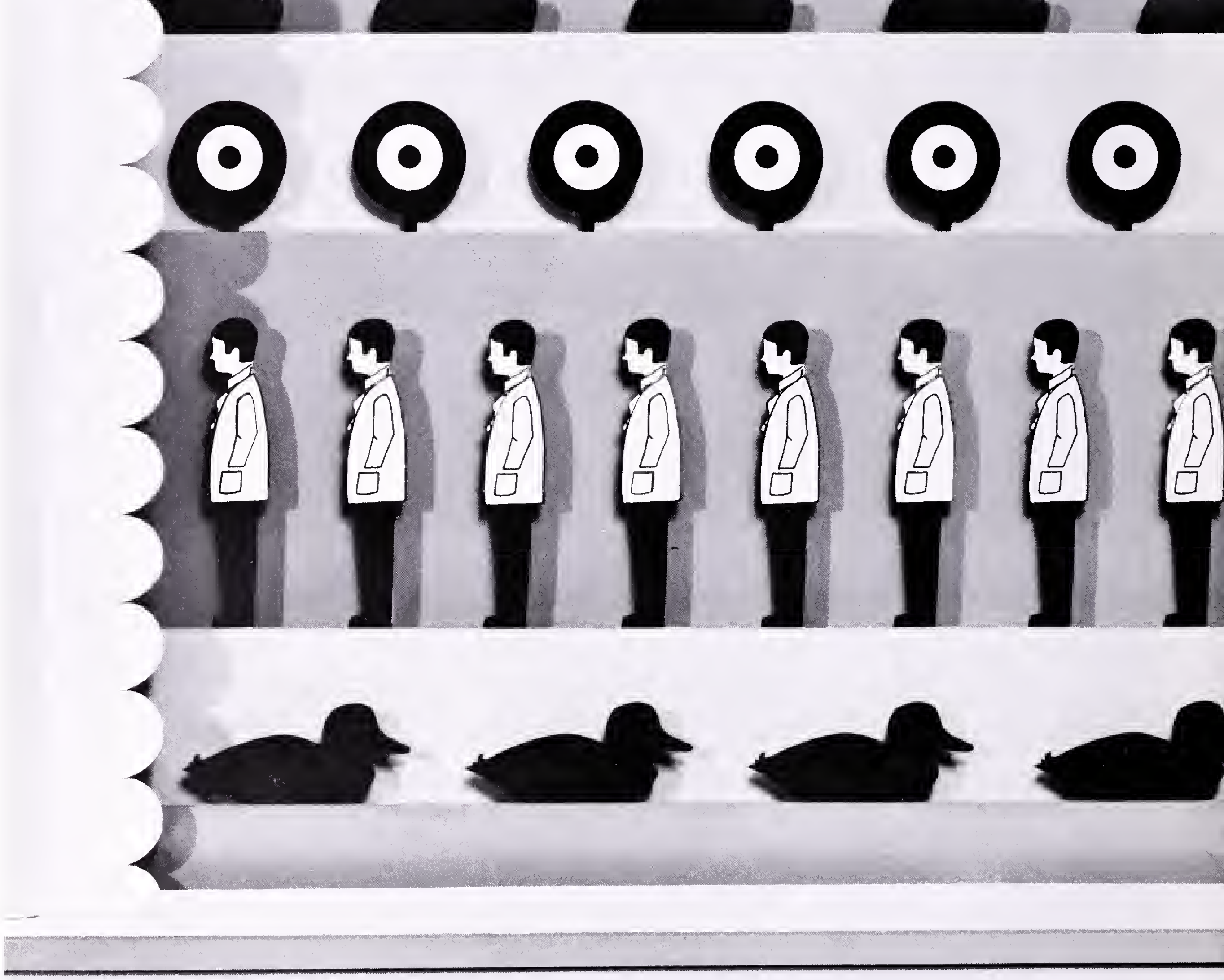
Keflex®
cephalexin

Additional information available to the profession on request.

DISTA
420113

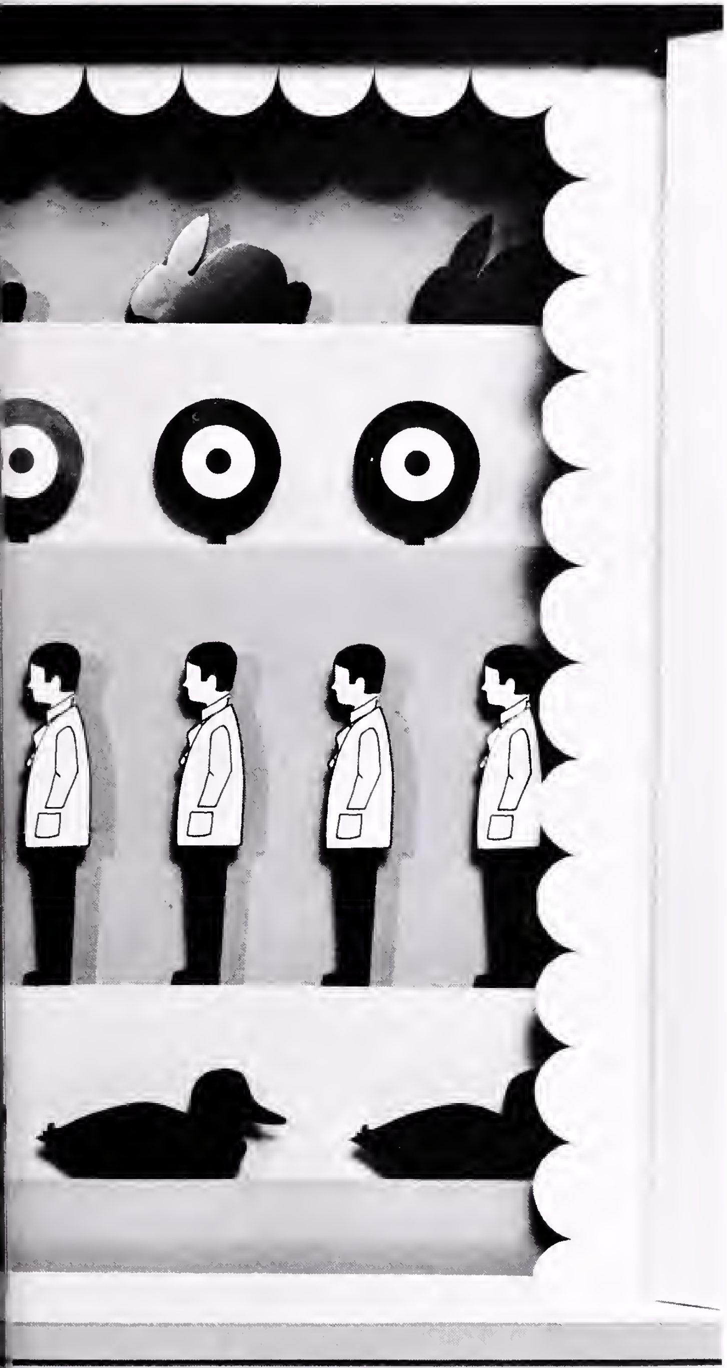
Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

If you become the target of a



©1983 MPMLC

professional liability claim...



You will be glad you have Michigan Physicians.

Michigan Physicians has been solving complex medical professional liability problems since 1976. With the state's largest and most experienced claims staff, Michigan Physicians works with you to resolve claims (and incidents) that most physicians have never faced in their careers.

In a changing legal environment, you need the best coverage you can buy because the risk of a professional liability claim is becoming greater every day.

For a confidential rate quotation and more information about Michigan's leading physician-owned insurance company, call or write the office in your area.

Michigan Physicians
Mutual Liability Company

1305 Abbott Road
East Lansing, MI 48823
(517) 351-1150
(800) 292-1926

6735 Telegraph Road
Suite 205
Birmingham, MI 48010
(313) 647-5550

Endorsed by the Michigan State Medical Society

Professional
INSTALLMENT
LOANS

$15,000
TO
$90,000

Decision In
24 to 48 Hours!

Same-Day Answer
to Applications
Received By Express Mail

- Deal Directly With Lender
- Deferred Payment Plans
- No Prepayment Penalty
- No Restriction on Use of Funds For:
  Investments
  Payment of Taxes
  Debt Consolidation
  Tax Shelters
  Pension Plan Contributions

Ask for Tom Todd

CALL TOLL FREE:
800-423-5025

Serving The Medical
Profession Since 1966

WOODSIDE
CAPITAL
CORP.
National Headquarters
Woodside Capital Building
21424 Ventura Boulevard
Woodland Hills, California 91364

MSMS, MSMS/A, AMA, and medical assistants

July 18 — MSMS practice management seminar for medical assistants, Flint, contact: Kirk McMurray, MSMS headquarters.

July 26-29 — Midsummer Meeting, MSMS Board of Directors, Deer Lake, Boyne Mountain, contact: Warren F. Tryloff, MSMS headquarters.

August 1 — MSMS practice management seminar for medical assistants, Southfield, contact: Kirk McMurray, MSMS headquarters.

Sept. 19 — MSMS Board of Directors meeting, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Oct. 25 — MSMS Leadership Conference, Long's Convention Center, Lansing, contact: William Madigan, MSMS headquarters.

Nov. 13-15 — MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn, contact: Sherry Fent, MSMS headquarters.

Nov. 21 — MSMS Board of Directors meeting, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Dec. 2-5 — Interim meeting of AMA House of Delegates, Honolulu, Hawaii, contact: Bruce Ambrose, MSMS headquarters.

deLORIMIER

"You've all got a new strain of V.D. I'm calling it 'Band-AIDS'."

Other meetings

July 14 — Pakistani Physicians of North America, Detroit, contact: Amanullah Khan, MD, President, Association of Pakistani Physicians, 800 Eighth Avenue, Suite 200, Fort Worth, Texas 76104.

July 23-25 — 38th Annual Scientific Assembly, Traverse City, sponsored by Michigan Academy of Family Physicians, contact: Dru Love, Executive Secretary, Michigan Academy of Family Physicians, 109 E. Oakland, Lansing 48906.

August 9-12 — Michigan Psychiatric Society Scientific Meeting, Grand Traverse Resort, contact: MPS (313) 552-8666.

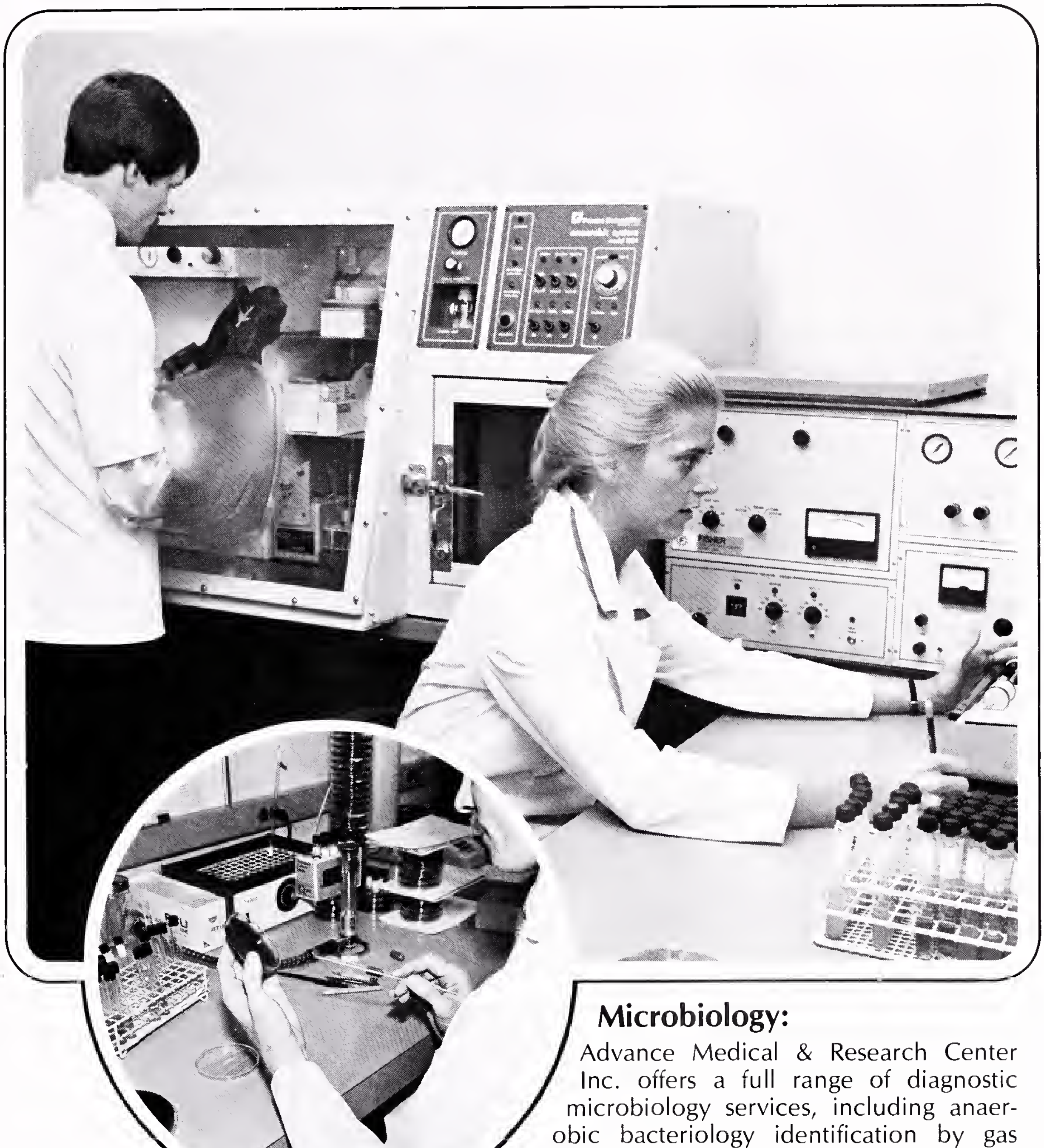
August 22-24 — Annual Meeting, Michigan Health Officers Association, Traverse City, contact: Bruce B. Bragg, President, MHOA, PO Box 24143, Lansing 48909.

September 25-26 — 17th Annual Great Lakes Cancer Nursing Conference, Lansing Hilton Inn, contact: American Cancer Society Michigan Division, Inc.

October 11-14 — ACP/MSIM Annual Regional Scientific Meeting, Boyne Highlands Resort, Harbor Springs, sponsored by Michigan Chapter, American College of Physicians in association with Michigan Society of Internal Medicine, contact: Arnold R. Axelrod, MD, FACP, Department of Medicine, Sinai Hospital of Detroit, 6767 West Outer Drive, Detroit 48235 (313) 493-5780.

October 27 — Annual Meeting of Michigan Neurological Association, Botsford Inn, Farmington, contact: Raymond B. Bauer, MD, 4201 St. Antoine 6G, Detroit 48201 (313) 494-4281

November 7-9 — Occupant Protection and Alcohol Countermeasures, Boyne Mountain, contact: Michigan Life Savers, Office of Highway Safety Planning, 111 S. Capitol, Lower Level, Lansing 48913.



Microbiology:
Advance Medical & Research Center Inc. offers a full range of diagnostic microbiology services, including anaerobic bacteriology identification by gas chromatography and mycology studies. Prominent microbiologist and co-director, Dr. Joseph P. Truant, heads the Department of Microbiology.

ADVANCE MEDICAL & RESEARCH CENTER, INC.
1270 Doris Rd. • Pontiac, Michigan 48057 • (313) 373-9120
Branches: Allen Park, Alpena, East Jordan, Flint,
Grand Rapids, Kalamazoo, Lansing, Monroe, Traverse City

Serving the medical profession since 1963

Do you know

a physician
with problems
of alcoholism,
drug abuse,
emotional illness
or other
difficulties
which interfere with
his or her ability
to practice medicine?

If so, please contact your MSMS Program to Assist Impaired Physicians through Katie Brewbaker at MSMS headquarters, (517) 337-1351.

MICHIGAN STATE MEDICAL SOCIETY
1866

References:
1. Stone PH, Turi ZG, Muller JE. Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104 672-681, September 1982
2. Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary-artery spasm Experience in 127 patients *N Engl J Med* 302 1269-1273, June 5, 1980

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. **Vasospastic Angina**: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine or 3) angiographically demonstrated coronary artery spasm In those patients who have had angiography the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e g , where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is retractory to nitrates and or adequate doses of beta blockers

II. **Chronic Stable Angina (Classical Effort-Associated Angina)**: PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and or organic nitrates or who cannot tolerate those agents

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs (See Warnings)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA

WARNINGS: **Excessive Hypotension**: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated occasional patients have had excessive and poorly tolerated hypotension These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers

Severe hypotension and or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone with low doses of fentanyl, in other surgical procedures or with other narcotic analgesics cannot be ruled out In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina probably related to increased sensitivity to catecholamines Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation It is important to taper beta blockers if possible rather than stopping them abruptly before beginning PROCARDIA

Congestive Heart Failure: Rarely patients usually receiving a beta blocker have developed heart failure after beginning PROCARDIA Patients with tight aortic stenosis may be at greater risk for such an event

PRECAUTIONS: **General**: **Hypotension**: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested Close observation is especially recommended for patients already taking medications that are known to lower blood pressure (See Warnings)

Peripheral edema: Mild to moderate peripheral edema typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA This edema occurs primarily in the lower extremities and usually responds to diuretic therapy With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction

Drug interactions: Beta-adrenergic blocking agents (See Indications and Warnings) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure severe hypotension or exacerbation of angina

Long-acting nitrates PROCARDIA may be safely co-administered with nitrates but there have been no controlled studies to evaluate the antianginal effectiveness of this combination

Digitalis Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers The average increase was 45% Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization

Carcinogenesis, mutagenesis, impairment of fertility When given to rats prior to mating nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose

Pregnancy Category C Please see full prescribing information with reference to teratogenicity in rats embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0 5% Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication Additionally, the following have been reported muscle cramps, nervousness dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis pruritus, urticaria, fever, sweating chills, and sexual difficulties Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension

In addition more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients It remains possible, however, that some or many of these events were drug related Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2% Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0 5% of patients

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase CPK LDH, SGOT, and SGPT have been noted and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy The relationship to PROCARDIA therapy is uncertain These laboratory abnormalities have rarely been associated with clinical symptoms Cholestasis, possibly due to PROCARDIA therapy has been reported twice in the extensive world literature

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41) The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container

More detailed professional information available on request

© 1982 Pfizer Inc

Pfizer LABORATORIES DIVISION
PFIZER INC

"I can do things that I couldn't do for 3 yrs. including joining the human race again."

Quotes from an unsolicited letter received by Pfizer from an angina patient.
While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

© 1983, Pfizer Inc

"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).

for the varied faces of angina

PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

*Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA *brief summary on adjoining page.*

Motrin®
ibuprofen, Upjohn
600 mg Tablets

MOTRIN
600mg

More convenient for your patients.

Upjohn

©1984 The Upjohn Company

The Upjohn Company • Kalamazoo, Michigan 49001 USA

J-4044 January 1984

The rules of the game

By Katharine S. Brown

Successful investing depends on a certain amount of careful planning. But it might also involve a little luck. For example, no amount of planning would have enabled you to predict that Maryland Cup would be bought out by Ford Howard Paper or that Quaker Oats would pay $77 a share for Stokely-Van Camp.

On the other hand, you can also be the victim of bad luck. You could, for instance, have invested your life's savings in the stock market in January of 1973, just before the market began a steep, two-year plunge of about 40 percent.

By and large, however, the good luck tends to offset the bad. Thus, your ultimate success depends upon your skill and knowledge and not on pure chance.

This is because the world of finance is incredibly complex, with thousands of securities to choose from. Worse yet, you are competing against a formidable foe — millions of investors who are bent on outwitting you. What's more, a few thousand of these investors may be better equipped for the fray than you. Some may have a better background, including degrees in economics, accounting, statistics and investment strategy. Worst of all, a few of these shrewd investors could be professionals who spend every waking hour deciding which stock to buy and sell.

To be sure, these full-time professionals are in the minority, but they control a great deal of institutional money. At the other extreme, of course, is the vast throng of individual investors who are ill-prepared to manage their own money.

Ms. Brown

Stock guidelines

If you are in this group, it would pay you to set up a few guidelines so that you can avoid some of the pitfalls that lie ahead. To give you a headstart, I have formulated a few rules which may help.

1. Read a good book on the stock market, such as *The Intelligent Investor* by Benjamin Graham, *Your Investments* by C. Colburn Hardy or *The New Contrarian Investment Strategy* by David Dreman.

2. Spend some time reading such periodicals as *The Wall Street Journal, The New York Times, Forbes, Financial World, Barron's* or *Business Week.*

3. Only three percent of shareholders give serious attention to annual and quarterly reports. Make sure you're in this select three percent. It should help you outmaneuver the apathetic 97 percent.

4. Don't put all your eggs in one basket, regardless how sure you are that you have discovered the world's greatest investment. Bear in mind that the ill-fated Washington Public Power System bonds were rated AAA when they were originally offered to investors. Those who invested heavily in these bonds have lived to regret it.

A good rule of thumb is to invest no more than 10 percent in any one industry. There are about 74 industries to choose from, so this should present no problem.

5. Don't over-diversify. You don't need to own 30 or 40 different stocks. For most investors, 10 to 20 is adequate. If each is in a different and unrelated industry, you should do all right.

6. Don't buy a stock unless you are willing to invest at least five percent of your assets in it. It makes no sense, for instance, to own 50 shares of Beatrice Foods in a $100,000 portfolio.

7. Don't be overly concerned with dividend income. For one thing, dividends are taxable as ordinary income. Capital gains are a far better deal in terms of taxes.

Admittedly, many investors are retired and have a clear-cut need for current income. Even so, capital gains are the best way to obtain this income. Most often you'll end up a lot richer owning stocks that yield four percent than you will with those that yield 11 percent.

8. Be a patient investor. Invest for the long term. If a company is a leader in its field, it could be a sound holding for 10 or 15 years, not merely 10 or 15 weeks.

9. Don't be a nervous investor. If you buy a stock for $25, avoid the impulse to take short-term profits at $30. Above all, don't pay any attention to people who tell you that "you can't lose money by taking a profit." There's a significant tax advantage to establishing long-term capital gains.

The reason I say this is simple: you don't win ballgames with singles and walks. You need a liberal sprinkling of doubles, triples and home runs.

Ms. Brown is an account executive with Prescott, Ball and Turben, investment banks and brokers, East Lansing. She is consultant to the MSMS Board of Managers on the investment of the MSMS capital and creative reserve funds assets.

Translated into the investment scene, this means you need your share of stocks that will double, triple or quadruple. If you are impatient and sell them when they are singles, you won't have any home runs, and you need home runs to cover up for the errors and strike outs. In every portfolio, there are bound to be some disappointments. Perhaps as many as 30 percent will not measure up.

Learn terms

10. Become familiar with financial terms and ratios which often appear in analysts' reports. Here is a brief rundown to get you started:

(a) Return on shareholders' equity is calculated by dividing net profit by book value. Many people regard this as an important key in judging management's capability. The trend of this ratio is what I look for. A good example would be Consolidated Foods, which has improved its return on equity every year since 1976, with the return increasing from 12.4 percent to 17.3 percent. In sharp contrast, Anderson, Clayton's return was 11.5 percent in 1976 and has held nearly at that level ever since (it was 10.2 percent last year).

(b) Net profit margin is calculated by dividing net profit by revenues. This ratio varies from one industry to another, but five percent is fairly typical. In the food industry, here are some representative numbers: Borden (four percent), Campbell Soup (5.1 percent), Consolidated Foods (2.6 percent) and Heinz (5.2 percent). At the high end of the spectrum are pharmaceuticals: Eli Lilly (13.9 percent), Pfizer (9.6 percent), Merck (13.6 percent) and Bristol-Myers (9.7 percent).

(c) Also significant is shareholders' equity as a percentage of total capitalization. The three principal components of capitalization are common equity, long-term debt and preferred stock. Here again, this relationship varies from one industry to another. You should give preference to companies with the most common equity. In the electric utility group, debt is high, so common equity averages only about 38 percent.

11. Don't be overly concerned with the price of a stock. Many investors, for instance, think IBM (at $120 a share) is too expensive, because they can't afford 100 shares. What's wrong with owning 20 or 30 shares? Actually, IBM is *not* an expensive stock, relative to its quality, financial strength and marketing skill. Besides, IBM sells at only 14.8 times earnings. Many other high-tech stocks sell at 30 and 40 times earnings.

12. This brings us to the importance of the price/earnings ratio (sometimes called the multiple). It is calcualted by dividing the earnings per share into the price of the stock. To illustrate, IBM earned $8.09 in the most recent 12-month period. Divide $8.09 into $120 and you get a P/E of 14.8, which is modestly above the level of stocks in general.

A great deal has been written about the importance of the P/E ratio. This concept is discussed in great detail by David Dreman in his excellent book, *The New Contrarian Investment Strategy.* He proves rather conclusively that low-multiple stocks — although you can point to many exceptions — out-perform the high-multiple counterparts. This becomes particularly apparent in the weak market we have experienced this past summer. The ones that came crashing down were generally the high flyers, not the stodgy issues such as foods and utilities, which have P/E ratios that are well below the rest of the market.

FINANCIAL ADVISOR
ENGLEMAN

"Let me put it this way, doctor, your stock portfolio needs major surgery!"

Payout ratio

13. Also important is the payout ratio. This is calculated by dividing the annual dividend by the earnings per share. Northern States Power ($35), for instance, has an annual dividend of $2.96. Divide this by the latest 12-month EPS of $5.29 and you get a payout ratio of 56 percent. This is an extremely low ratio for an electric utility. Most power companies pay out close to 80 percent. A low payout is best because it gives greater protection to the dividend and provides a cushion that enables the company to raise the dividend even when earnings are flat. Even more important, a high retention of profits allows the company to finance its expansion with internally generated funds. Utilities that dole out the bulk of their profits to shareholders are usually forced to borrow money to build new plants, or (even worse) sell new shares. Northern States Power expects to finance 95 percent of its construction program in the eighties internally.

14. Don't spend too much time worrying about what the market will do. This complex subject is best left to the professionals. As you already may have observed, these pros are not always right — nor do they always agree with one another. If you want to simplify your decisions, don't base your strategy on what you think the market will do over the next six months. Instead, put your main emphasis on which stocks to buy.

15. When to sell is always a problem. If you tend to keep your stocks less than a year, you may be paying too much in taxes and commissions. By the same token, if you rarely make a trade, you are probably letting your garden grow up with weeds. A good rule of thumb is to sell your worst stock at least once or twice a year. Let's hope you can determine which one is the worst.

DIMENSION III

LOW-COST HEALTH CARE COVERAGE FROM BLUE CROSS AND BLUE SHIELD OF MICHIGAN.

Blue Cross
Blue Shield
of Michigan
SUBSCRIBER NAME
VALUED CUSTOMER
EFFECTIVE DATE OF CURRENT COVERAGE
01 01 83
GROUP NO
94000
1270
7007 3260
CONTRACT NUMBER
365 036 429 0 210
BLUE CROSS OF MICHIGAN (210) BLUE SHIELD OF MICHIGAN (710) DETROIT MICH 48226

Now there's a new low-cost health care plan for Michigan State Medical Society members and their employees. It's Dimension III from Blue Cross and Blue Shield of Michigan... a health care plan in which the subscriber shares in the cost of the covered services. Dimension III is a lower cost alternative to the other health care plans presently available to doctors and their employees. Here's how the plan works.

Dimension III for doctors:
Deductible—$ 500 one person
$1,000 family

Dimension III for employees:
Deductible—$100 one person
$200 family

Once the deductible amount has been met, Dimension III pays 80% and the subscriber pays a 20% copayment for covered health care services. When the subscriber has paid $1,000 in copayments, no further copayments are required. Dimension III pays 100% up to $1 million. And when you select one of these plans, you'll get all the benefits that characterize the best health care coverage available:

☐ Hospital care benefits.
☐ Surgery.
☐ Maternity care.
☐ Outpatient care benefits.
☐ Psychiatric care benefits.
☐ The I.D. card that's recognized everywhere.
☐ A minimum amount of paperwork.
☐ A statewide network of Blue Cross and Blue Shield Service Centers to assist you and your employees.
☐ Worldwide coverage for you and your family.

Blue Cross and Blue Shield coverage is the choice of over 5 million Michigan residents. Why not make it your choice, too? For enrollment information, call your local Blue Cross and Blue Shield of Michigan representative.

CAN YOU AFFORD LESS?

Blue Cross
Blue Shield
of Michigan

NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Mary L. Angelilli, MD — U
16647 Collingham
Detroit 48205

David R. Antonenko, MD — GS
3990 John R.
Detroit 48201

Sylvanus A. Ayeni, MD — N
1414 W. Fair Ave.
Marquette 49855

Lee W. Beville, MD — R
49041 Denton #208
Belleville 48111

Robert D. Beyer, MD — OBG
509 Hazen St.
Paw Paw 49079

Sidney F. Bottoms, MD — OBG
4707 St. Antoine
Detroit 48201

William L. Bristol, MD — IM
21321 Kelly Rd.
East Detroit 48021

Bryan D. Buller, MD — EM
1711 W. Fulton
Grand Rapids 49504

Steven K. Campbell, MD — FP
658 Graefield Ct.
Birmingham 48008

Lance M. Christiansen, MD — OBG
620 N. Woodward
Birmingham 48013

Harry T. Colfer, MD — IM
Burns Clinic Medical Ctr.
Petoskey 49770

Anna M. Constan, MD — PD
Henry Ford Hosp.
Detroit 48202

James R. Creps, MD — P/IM
19401 Hubbard Dr.
Dearborn 48126

Irene S. Danek, MD — GP
925 Huron Hills Dr.
Traverse City 49684

Hugh G. Deery, II, MD — IM
560 W. Mitchell
Petoskey 49770

Gunter Deppe, MD — OBG
4707 St. Antoine
Detroit 48201

Sheela Dharmani, MD — OBG
2763 Broadmour Ct.
Rochester 48063

Deepa Dixit, MD — PD
6500 John Lodge
Detroit 48202

Ray S. Dixon, MD — OPH
17100 W. 12 Mile Rd.
Southfield 48076

Kristine M. Duffy, MD — OBG
13142 Hart
Huntington Woods 48070

John F. Duge, MD — IM/CD
1130 St. Joseph St.
Berrien Springs 49103

Kim J. Eastman, MD — ORS
816 Fairmount, SE
Grand Rapids 49506

John M. Egger, MD — FP
1601 E. Michigan Ave.
Lansing 48912

William R. Elliott, MD — FP
415 S. Church St.
Hudson 49249

$EMINAR$

*FINANCIAL SEMINARS FOR MEDICAL PROFESSIONALS

1984-85 SERIES BY WORLDWIDE FINANCIAL SEMINARS, INC.

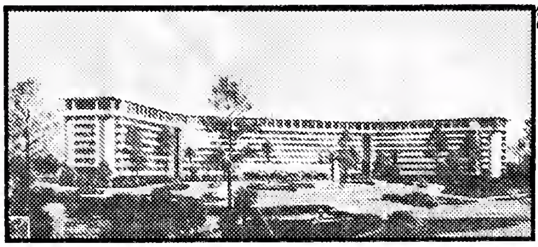
Seminars held in **Orlando, Florida at the new, luxurious Hilton at the **Walt Disney World** Village Hotel Plaza (special Seminar room rate).

Two full Thursday and Friday morning sessions throughout the year. Pick your own dates.

FOR SEMINAR INFORMATION, WRITE OR CALL *COLLECT*;
The Benn Group,
1118 Knights Place,
Lakeland, FL 33803, (813) 646-3892

**The financial Seminar program is designed to comply with Federal tax law regarding tax deductibility.*

Staff comprised of highly qualified investment, financial planning, managed account specialists/authors from leading international investment firm.



***Year-round Area Attractions — Walt Disney World • Sea World • Cape Canaveral • Beaches • Golf • Tennis • Swimming • Deep Sea Fishing*

Michael A. Engel, MD — DR/NR
1215 E. Michigan
Lansing 48912

William R. Eppler, MD — OPH
847 N. Center #1
Gaylord 49735

Steven J. Feldman, MD — IM
25865 W. 12 Mile Rd. #104
Southfield 48034

Marcus S. Feldman, MD — ON
16001 W. 9 Mile Rd. Box 2043
Southfield 48037

Jerry W. Froelich, MD — R
2799 W. Grand Blvd.
Detroit 48202

Howard I. Frumin, MD — IM/CD
6767 W. Outer Dr.
Detroit 48235

Michael Fusillo, MD — P
551 ½ Linn St.
Allegan 49010

Mark R. Glasberg, MD — N/NA
2799 W. Grand Blvd.
Detroit 48202

Neal W. Gogan, MD — EM
5916 Oakland Dr.
Kalamazoo 49002

Penbe M. Gokcora, MD — P
22896 Walsingham Dr.
Farmington Hills 48024

Mark Gostine, MD — A
2727 Albert Dr., SE
Grand Rapids 49506

James C. Gruenberg, MD — GS
6265 Thorncrest Dr.
Birmingham 48010

John D. Hall, MD — OBG/EM
22850 Kelly Rd.
East Detroit 48021

Edmund D. Harris, MD — DR
15095 Rosemont
Detroit 48223

Safiul Hasan, MD — IM/GE
1575 Woodward Ave. #705
Bloomfield Hills 48013

Maria Ferroro Hayes, MD — END/OBG
4727 St. Antoine #308
Detroit 48201

Michael J. Hepner, MD — A/IG/IM
26076 W. 12 Mile Rd.
Southfield 48034

continued on page 364

Prepare For:

- TOEFL
- MSKP
- NATIONAL MEDICAL BDS
- VQE
- ECFMG
- FLEX
- DENTAL BDS
- PODIATRY BDS
- NURSING BDS

- Voluminous home study notes on all areas of basic science.
- Teaching tests accompanied by comprehensive teaching tapes to be used at any of our tape centers.
- Materials constantly updated.
- Over 40 years of experience and success in the field of test preparation.

Stanley H. KAPLAN
EDUCATIONAL CENTER

For information Please Call:
Ann Arbor (313) 662-3149
Detroit (313) 569-5320
E. Lansing (517) 332-2539
Centers in More than 115 Major U.S. Cities, Puerto Rico and Toronto, Canada

PHYSICIAN

One of Chicagoland's largest manufacturing plants is seeking a physician for its staff.

This plant's Medical Department has a staff of three (3) physicians, including a director, participating in a well equipped and modern medical facility. Opportunities for professional growth and rapid advancement are excellent.

The Medical Department includes a fully staffed complex with an x-ray unit, laboratory and clinic facility. It has a full range of medical activities including traumatic preplacement and consulting services. It also includes an Occupational Hygiene division having a comprehensive program for evaluation of environmental exposure.

An outstanding company paid fringe benefit package is included. Salary available is open depending upon the candidate's experience. Experience in industrial and/or family medicine essential.

Normal working hours are 8AM to 5PM, Monday through Friday. A wide variety of desirable locations in which to live are available. Reply in confidence to:

Mr. D.J. Conces
Technical Director, Dept. 7-500

Inland Steel
3210 Watling Street
East Chicago, Indiana 46312
An Equal Opportunity Employer M/F

PRACTICES FOR SALE

FAMILY PRACTICE—Mt. Clemens area. Beautiful equipment and office furniture. Practice is within large medical complex with complete radiology and blood work facilities. 2000 sq. ft.

THORACIC/CARDIOVASCULAR PRACTICE — Downriver area, good equipment and nice building. Terms available. Well-established. Marvelous Opportunity!

MEDICAL PRACTICE — Allen Park area. Nice building. Call today to receive more information on this practice opportunity.

FAMILY PRACTICE—Redford area. Excellent equipment and office furniture. Well-established practice. Building and rental included.

INTERNAL MEDICINE—East Detroit area. Big earnings, lots of equipment. **MUST SEE!**

MEDICAL PRACTICE—Lansing area. Industrial and family, good equipment. Also, building is optional. **Great Opportunity.**

Professional Practice Sales, Inc.
27208 Southfield Road
Lathrup Village, Michigan 48076
HERBERT SILVERMAN, BROKER
(313) 569-7336

Gregory L. Henry, MD — EM
1421 Brooklyn St.
Ann Arbor 48104

James Heron, MD — FP/EM
155 Brookton Rd.
Marquette 49855

Camilla C. Hersh, MD — OBG
2863 Marshall
Ann Arbor 48104

W. S. Hicks, MD — FP
210 W. John
Newberry 49868

Henry N. Ho, MD — OTO
3625 Brewster
Dearborn 48120

Sean J. Hoban, MD — GP
1480 W. Center Rd.
Essexville 48732

John F. Itnyre, MD — OBG
520 Cobb St.
Cadillac 49601

Eric J. Ittner, MD — FP
1414 W. Fair Ave.
Marquette 49855

Mary L. Jackson-Hammond, MD — OM
981 Ironwood Dr.
Rochester 48063

Mark J. Jaffe, MD — D
1095 W. Huron
Pontiac 48053

John A. Jansen, MD — EM
1241 Hampshire
Canton 48188

Charles C. Johnston, MD — EM
302 Kensington Ave.
Flint 48502

John P. Jones, MD — PTH
211 Cinnabar
Williamston 48895

Zdzislaw Jurek, MD — PM
2345 Merriman Rd.
Westland 48185

Chung Kook Kim, MD — DR
44663 N. Hills Dr. #49E
Northville 48167

Carolyn Koppenol, MD — P/CHP
630 Walnut
Alpena 49707

Jennifer L. Kozar, MD — GP
709 W. Adams
Mt. Pleasant 48858

Anjali Kumar, MD — IM/PUD
3800 Woodward #300
Detroit 48201

Suryarao Kurumety, MD — DR
515 N. Michigan Ave.
Saginaw 48602

Albert M. Lai, MD — TS/CDS/GS
710 North Ave.
Battle Creek 48017

Kathleen L. Lemmen, MD — PD
2901 S. Westnedge
Kalamazoo 49009

Harvey B. Leslie, MD — IM
296 Coachman Dr. #3-B
Troy 48083

Sheldon Lincenberg, MD — GS
26100 W. 12 Mile Rd. #330
Southfield 48034

Prarop Liptawat, MD — GP
3120 Carpenter
Hamtramck 48212

continued on page 370

TAKE A BREAK EACH WEDNESDAY

Health Care News
Your FREE HCN Coffee Cup!

with **Health Care News**, the most accurate, reliable, and complete way to keep abreast of health care regulations, legislation, mergers, moves, negotiations, people, continuing education, and job opportunities. We give you the news you need to know **52 times a year for only $11. $20 for 2 years & a free coffee cup.**

Subscribe now. Limited time only.

Health Care News

SERVING MICHIGAN'S HEALTH CARE PROFESSIONALS

☐ Payment Enclosed
☐ New
☐ Renewal
☐ Bill me—$1.50 additional
☐ Bill firm—$1.50 additional
☐ Visa ☐ Mastercard

Firm Name (if applicable)__________
Name __________
Address__________
City/State/Zip __________
Interbank #__________ Exp. Date __________
Signature__________
Drivers License Number __________

5440 Cass Avenue • Detroit, Michigan 48202 • (Phone (313) 831-3323
Telephone Orders Accepted

1953.

- General Dwight D. Eisenhower was inaugurated President of the United States; his vice president was Richard M. Nixon.
- The Korean armistice was signed to end the Korean War.
- Not one home owned an electronic calculator or color TV.
- It cost 3¢ to mail a letter.
- The Studebaker was the "new American car with the European look."
- Jacqueline Bouvier was engaged to U.S. Senator John F. Kennedy; **and**
- **the Stratton Agency began serving the Michigan State Medical Society!**

We have appreciated your participation and support over the past 30 years. If you would like additional information about our services, we would be happy to hear from you.

STRATTON-CHEESEMAN & ASSOCIATES, INC.
1305 Abbott Road, P.O. Box 1563
East Lansing, Michigan 48823

800-292-1926

By Joyce Crum

Ingall

Hunt

Bornstein

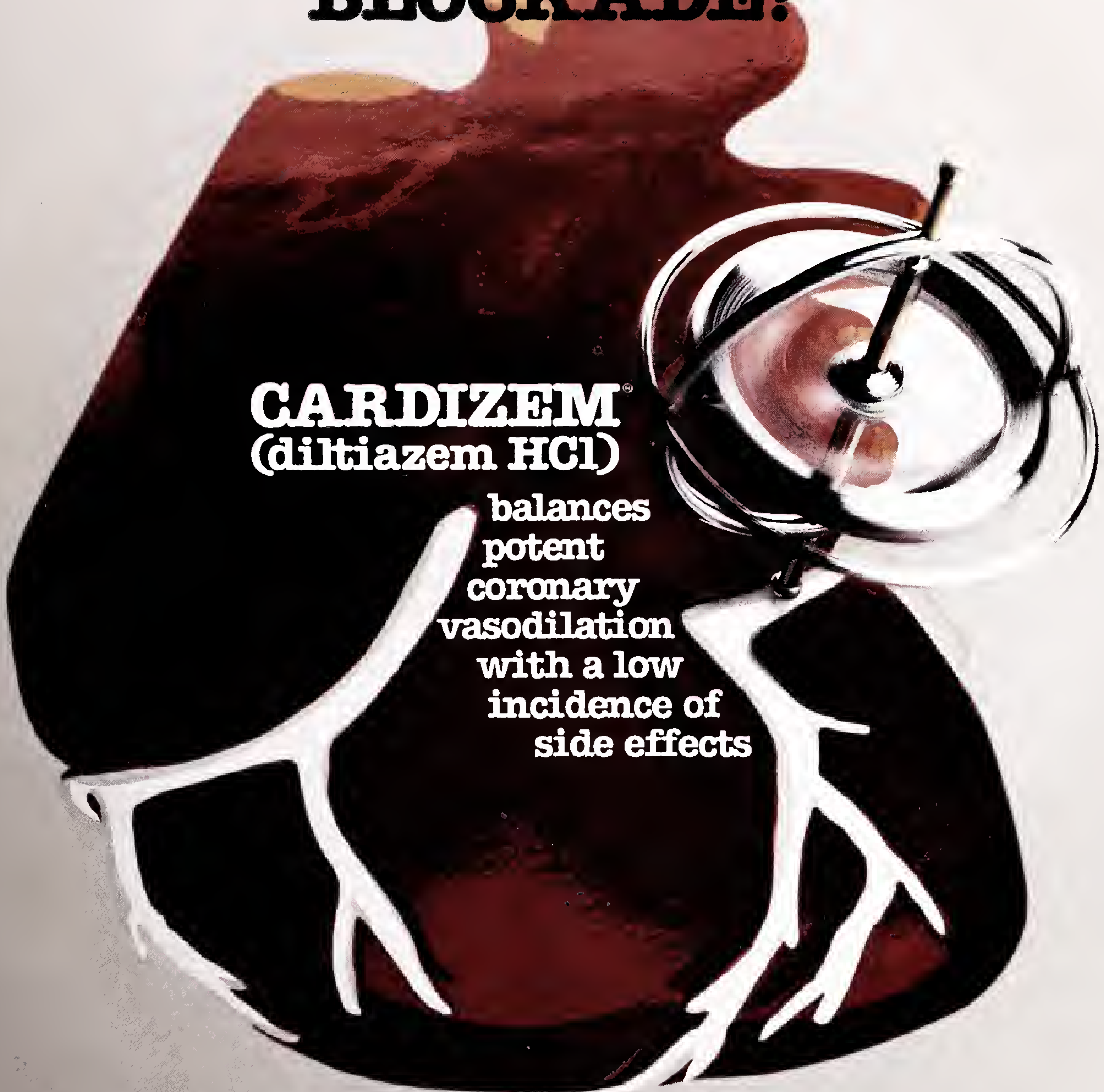
Battley

Ziel

DeKornfeld

John R.F. Ingall, MD, Detroit Medical Director of Michigan Cancer Foundation, has been invited to participate in the Citizen Ambassador Program to China of People to People International. This program was founded by President Dwight D. Eisenhower in 1956 to foster goodwill and understanding between Americans and citizens of other countries ... Appointed associate chief of clinical affairs at the University of Michigan Hospitals is **S. Martin Lindenauer, MD,** Ann Arbor. Doctor Lindenauer previously served as chief of staff at the Veterans Administration Hospital in Ann Arbor and as assistant dean of the University of Michigan Medical School. More recently he has been director of undergraduate surgical education at the U-M ... **Debra Robinson, MD,** resident physician in internal medicine, and **Leo J. Bingley, Jr., MD,** associate director of education in internal medicine, both at McLaren Hospital, Flint, won first place for their scientific poster presentation entitled "Staphylococcus Aureus Meningitis: A Case Report with Emphasis on Recent Therapeutic Recommendations." The poster was presented at the sixth annual Associates Meeting of the American College of Physicians, Michigan Chapter ... **Andrew D. Hunt, MD,** East Lansing, founding dean of Michigan State University's College of Human Medicine, is retiring after 20 years with the University. Doctor Hunt is nationally recognized for his innovative approach to medical education. ... **Melvin Bornstein, MD,** Birmingham, is new president of the Michigan Psychiatric Society. Doctor Bornstein is clinical associate professor in the Department of Psychiatry at Wayne State University. The new president-elect is **George Newman, MD,** Dearborn psychotherapist. ... The American Academy for Law and Psychiatry, Midwestern Chapter, elected **Emanuel Tanay, MD,** Detroit, its new president recently ... Each year the Michigan Hospital Association awards the Joseph R. Homminga Memorial Award to a health care administrator for outstanding contributions to Michigan hospitals in the field of facilities planning and construction. This year the MHA selected **Hermann Ziel, Jr., MD,** Perry, chief of Michigan Department of Public Health's Bureau of Health Facilities as their recipient ... **Thomas J. DeKornfeld, MD,** Ann Arbor, is new chairman of the Health Occupations Council for the state of Michigan. According to Doctor DeKornfeld, the main responsibilities of the council are to recommend and endorse standards for any emerging health profession and to ensure that the rules of the various licensing boards match the Michigan Health Code ... The American College of Allergists conferred its highest award on **James C. Breneman, MD,** Galesburg, when he received the "Distinguished Fellow Award" at its 40th Annual Congress, in San Francisco. This award is presented each year to the physician or physicians who have exhibited outstanding dedication and leadership in the field ... **Barbara Johnson,** Lansing, a University of Michigan Medical Student, is among 20 "academically outstanding" minority students who have been named 1984 Commonwealth Fund Fellows and awarded $5,000 to support research projects. Ms. Johnson will study the effects of methylphenidate (Ritalin) on children ... **H. David Humes, MD,** Ann Arbor, is new chief of the medical service at the Ann Arbor Veterans Administration Medical Center. Doctor Humes served for two years as chief of the nephrology section of the VA facility ... Past MSMS President, **Gilbert B. Saltonstall, MD,** Charlevoix, was honored when the Charlevoix Area Hospital formally announced the naming of the hospital's new surgical wing for him. Hospital officials cited his high standard of practice in medicine and surgery which has served as an inspiration to others. ... **Steven W. Werns, MD,** Ann Arbor, has been selected, along with two other physicians, to receive the $25,000 Adult Cardiology Fellowship Training Award for 1984-85. The purpose of the one-year fellowship is to encourage development of new programs in clinical and preventive medicine that might have a positive effect on high morbidity and mortality statistics for cardiovascular disease. ... The pediatrics unit of the Port Huron Hospital has been named for **John Charles Sinclair Battley, MD,** Port Huron. Doctor Battley, 92, was the first chief of pediatrics at Port Huron Hospital and practiced there from 1928 to 1969 ... **Jack Ryan, MD,** Detroit, president of Detroit-Macomb Hospital Corporation, has been elected a board member of the Southeast Michigan Hospital Council of the Michigan Hospital Association ... **D. Bonta Hiscoe, MD,** medical director of Lansing's Health Central HMO, is one of four persons for whom a new Health Central facility has been named.

BALANCED CALCIUM CHANNEL BLOCKADE!


CARDIZEM®
(diltiazem HCl)
balances potent coronary vasodilation with a low incidence of side effects

Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

Please see full prescribing information on following page.

2/84

---

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

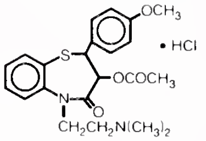
References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy)-5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+)-cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral/LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 4/1/84

Another patient benefit product from
M PHARMACEUTICAL DIVISION
MARION
LABORATORIES, INC.
KANSAS CITY, MISSOURI 64137

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, (517) 337-1351.

Date: July 19-22, Macula Disease. Location: Mackinac Island. **Sponsor:** Michigan Ophthalmological Society. **Contact:** Leslie E. Meissner, MOS Administrator, 302 Eastland Professional Building, Harper Woods, 48225. **Approved for:** 8 hours of Category I Credit.

Date: July 23-25, 38th Annual Scientific Assembly. Location: Traverse City. **Sponsor:** Michigan Academy of Family Physicians. **Contact:** Dru Love, Executive Secretary, Michigan Academy of Family Physicians, 109 E. Oakland, Lansing, 48906. **Approved for:** 15.75 hours of Category I Credit (19-Wyeth Autotutors, 16-ACLS Course).

Date: July 26-27, Coller Penberthy Thirlby Medical Conference. Location: Park Place Hotel, Traverse City. **Sponsor:** Munson Medical Center. **For:** All interested physicians. **Contact:** Norma Powers, Coordinator of Medical Education, Munson Medical Center, 6th and Madison Streets, Traverse City 49684 (616) 922-9544. **Approved for:** 9 hours of Category I Credit.

Date: August 1-3, Total Knee and Hip Arthroplasty. Location: Boyne Highlands. **Sponsor:** Burns Clinic Foundation. **Contact:** Kay Kelly, Continuing Medical Education, Northern Michigan Hospitals, Inc., Petoskey 49770, (616) 348-4500. **Approved for:** 20 hours of Category I Credit.

Date: August 13-17, Tutorial on Direction Action Thrust Manipulative Therapy. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU College of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A306 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

Date: August 18-19, Regional Anesthesia: Anatomy and Techniques. Location: Detroit Medical Center. **Sponsor:** Wayne State University School of Medicine Departments of Anesthesia and Anatomy. **Contact:** Wayne State University School of Medicine, Continuing Medical Education, 4201 St. Antoine, Detroit 48201, (313) 577-1180. **Approved for:** 12 hours of Category I Credit.

Date: August 29-31, Controversies in Obstetrics and Gynecology. Location: Grand Hotel, Mackinac Island. **Sponsor:** American College of Obstetricians and Gynecologists. **Contact:** Patience A. Schenck, Division of Education, American College of Obstetricians and Gynecologists, 600 Maryland Avenue, SE, Washington, DC 20024. **Approved for:** 16 hours of Category I Credit.

Date: September 8, Pediatric Endocrinology. Location: St. John Hospital. **Sponsor:** CME Committee of St. John Hospital. **For:** Interested physicians. **Cost:** $90.00. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road, Detroit 48236 (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: September 8-9, Michigan Hypertension Update — 1984. Location: Bay Valley Inn. **Sponsor:** University of Michigan Medical School. **Contact:** Towsley Center, University of Michigan Medical School, (313) 763-1400. **Approved for:** 7 hours of Category I Credit.

Date: September 8-12, Fundamental of Muscle Energy. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU College of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A306 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

Date: September 10-12, Hemodynamic Monitoring. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School Dept. of Pathology and Office of Continuing Medical Education. **Contact:** Office of CME, Towsley Center, Box 057, U-M Medical School, Ann Arbor, 48109, (313) 763-1400. **Approved for:** 14.5 hours of Category I Credit.

Date: September 21-23, Tutorial on Myofascial Release Technique. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A306 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 24 hours of Category I Credit.

Date: October 6-10, Advanced Muscle Energy Tutorial (Above Diaphragm). Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A306 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

Date: October 17, Influencing Unfavorable Pregnancy Outcomes. Location: St. John Hospital. **Sponsor:** CME Committee of St. John Hospital. **For:** Interested physicians. **Costs:** $90.00. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road,Detroit 48236 (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: October 25-27, 15th Annual International Symposium on Implant Surgery for the Hand and Upper Extremity. Location: Blodgett Memorial Medical Center and Amway Grand Plaza Hotel, Grand Rapids. **Sponsor:** American Society for Surgery of the Hand. **Contact:** Alfred B. Swanson, MD, 290 Blodgett Professional Building, 1900 Wealthy Street, SE, Grand Rapids, 49506 (616) 774-7394. **Approved for:** 19 hours of Category I Credit.

Date: October 26-28, Manual Medicine Principles Applied to the Extremities. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A306 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 24 hours of Category I Credit.

Date: October 27, Annual Meeting of Michigan Neurological Association. Location: Botsford Inn, Farmington. **Contact:** Raymond B. Bauer, MD, 4201 St. Antoine 6G, Detroit 48201 (313) 494-4281. **Approved for:** 4 hours of Category I Credit.

Date: November 13, 14 & 15, Annual Scientific Meeting. Location: Hyatt Regency Dearborn. **Sponsor:** Michigan State Medical Society. **For:** All interested physicians. **Contact:** MSMS headquarters (517) 337-1351. **Approved for:** Maximum of 18 hours of Category I Credit.

Date: November 14, Alcoholism. Location: St. John Hospital. **Sponsor:** CME Committee of St. John Hospital. **For:** Interested physicians. **Cost:** $90.00. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road, Detroit 48236 (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: December 3-7, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine, and North American Academy of Manipulative Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A306 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

Date: February 27, 1985, Cardiology Update. Location: St. John Hospital. **Sponsor:** CME Committee of St. John Hospital. **For:** Interested physicians. **Cost:** $90.00. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road, Detroit 48236, (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: May 8, 1985, Pancreatitis. Location: St. John Hospital. **Sponsor:** CME Committee of St. John Hospital. **For:** Interested physicians. **Cost:** $90.00. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road, Detroit 48236, (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Michigan Board of Medicine

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are summarized below by MSMS legal counsel from official memoranda to MSMS.

Doctor Involved: Henry B. Bright, MD
Complaint: Multiple allegations of allegedly improper prescriptions for Desoxyn, not for diagnostic or therapeutic purposes.
Facts: Numerous allegations of specific episodes.
Decision: April 11, 1984 — Order of Summary Suspension of License
Status: Hearing set for May 18, 1984
Comments: Result of hearing not yet known.

Doctor Involved: Eugene Jakubowski, MD
Complaint: Unlawfully prescribing controlled substances in 1982; no lawful diagnostic or therapeutic purpose. Item involved: Preludin.
Facts: In 1982 respondent pled guilty to aiding and abetting distribution of Preludin, a felony.
Decision: Board's Final Order: license suspended for one year, effective April 16, 1984.
Comments: Lengthy Opinion by Administrative Law Examiner discloses four months of six-month sentence actually served; strong evidence of rehabilitation; now doing supervised residency work.

Doctor Involved: Robert M. July, MD
Complaint: Filed December 14, 1983; exact charges unknown to MSMS.
Decision: Consent Order entered March 8, 1984: license to practice suspended for one year, effective March 14, 1984, per stipulation of parties.
Comments: License had been summarily suspended by Board in December, 1983.

Doctor Involved: Akiyoshi Kido, MD
Complaint: Improper prescribing of valium: large quantities without specific evaluation; two and three open refills with no return visits scheduled.
Decision: Consent Order stipulated to. Consent Order: reprimanded; two years probation with quarterly review of prescription log and 50 hours of CME in addition to minimum required for licensed renewal, the CME to be in pharmacology. Order effective May 9, 1984.

Doctor Involved: Bruce R. Krygowski, MD
Complaint: Distribution of a controlled substance, Talwin.
Facts: In federal court, Respondent pled guilty to such charge.
Decision: By stipulation and consent order, license suspended for one year on May 9, 1984 but commencing at December 14, 1983.
Comments: Respondent is rehabilitated and has been reinstated in his medical employment.

Doctor Involved: Frederick J. Sawaya, MD
Complaint: That Respondent suffered from a mental or physical inability related to and adversely affecting his ability to practice.
Facts: Unproved; case pending.
Decision: Order of Summary Suspension, May 9, 1984, pendente lite.
Status: Case in process. Order to compel examination by a specified psychiatrist; results presently unknown.

Doctor Involved: Chelliah Thangavelu, MD
Complaint: Acts of sexual misconduct with patients and medical care below minimal standards.
Facts: (Will not bear repetition)
Decision: License revoked, effected April 30, 1984.
Comments: Extensive Opinion by Administrative Law Judge sustaining Complaint. In antecedent criminal actions on specific charges, Respondent ultimately found not guilty.

Doctor Involved: David S. Schane, MD
Complaint: Previously reported.
Facts: Previously reported. Allegations of improper drugs dispensing.
Decision: Previously reported. License suspended, with conditions. Wayne Circuit Court granted a stay of Board of Medicine's final order on March 11, 1983.
Status: Circuit Court's stay of Board of Medicine's final order was dissolved effective January 30, 1984.
Comments: Board's final order of February 9, 1983 now effective: license suspended for one year, on various conditions.
Date: March 7, 1984

NEW MEMBERS/continued

Tracy E. Liu, MD — PM
22401 Foster Winter Dr.
Southfield 48075

Frank A. Lopez, MD — PTH
401 Cherry Hill Trail #202
Inkster, 48141

Conrad C. Maitland, MD — U
17000 Southfield LL90
Detroit 48075

Vinay Kumar Malviya, MD — OBG
16500 N. Park Dr. #1906
Southfield 48075

James L. Marley, MD — OBG
1950 Manchester Rd.
Ann Arbor 48104

Katharine W. Mauer, MD — PD/A
7300 Middlebelt Rd.
West Bloomfield 48033

Antonio F. Mendiola, MD — GP
2590 N. Monroe
Monroe 48161

Steven E. Minnick, MD — IM
22151 St. Clair Prof. Bldg.
Detroit 48236

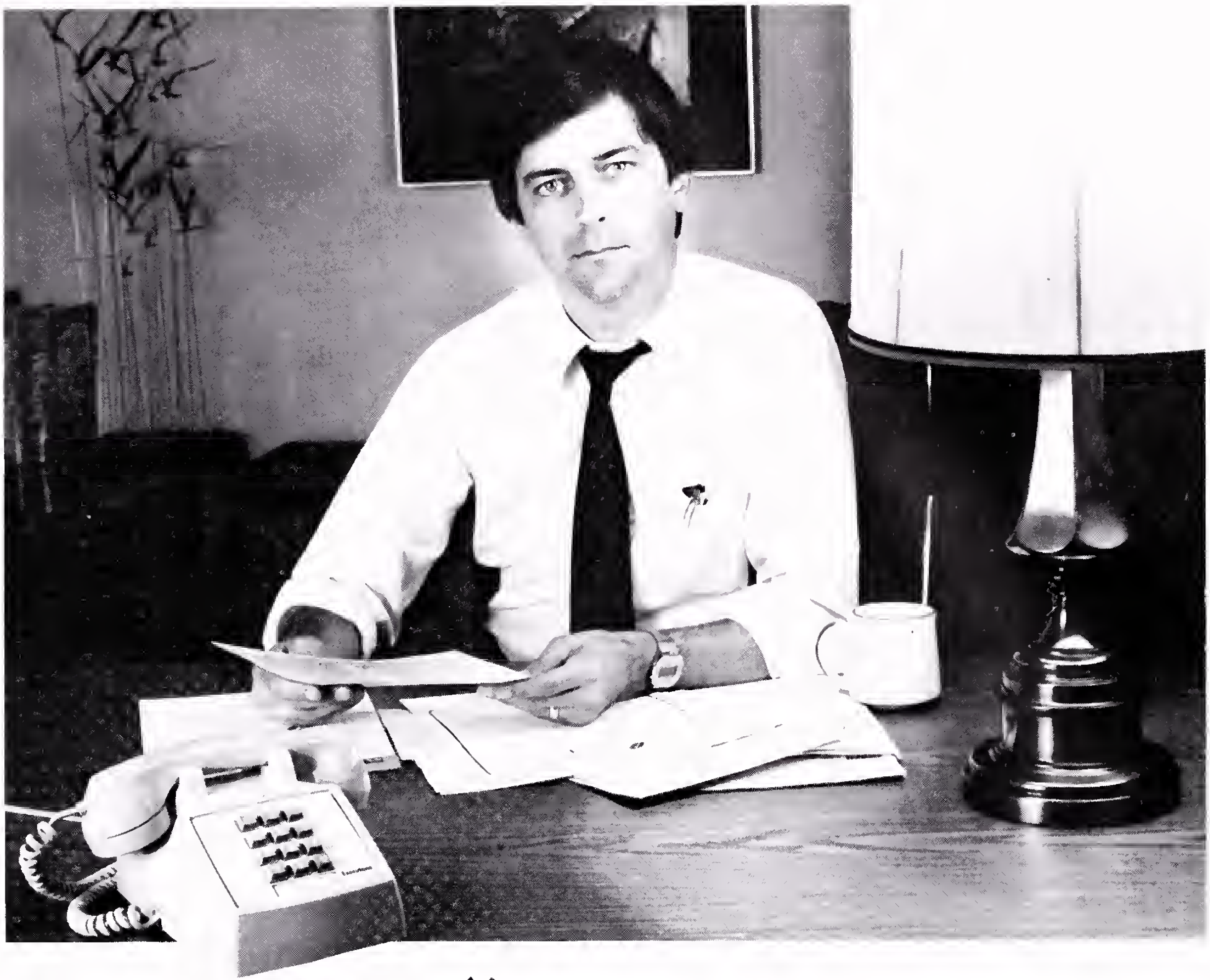
Kenneth L. Moss, MD —
31633 Summers
Livonia 48154

John W. Murphy, MD — GS
44199 Dequindre #102
Troy 48098

Khalil S. Nahra, MD — GS/CRS
28922 Horndonwood
Farmington 48018

Mohamad S. Nass, MD — DR
27463 Fourteen Mile Rd.
Farmington Hills 48018

Wayne M. Nevala, MD — IM
327 E. North St.
Owosso 48867



"...Your financial security specialist is on call"

American Physicians Life believes a physician's financial security deserves specialized attention. That's why our products and services are designed with the doctor in mind. Our comprehensive portfolio of services, including life insurance, professional disability income coverage, qualified plans and tax-deferred annuities, is customized to meet your personal financial planning needs as well as those of your professional corporation.

Let American Physicians Life secure your financial planning program—that's our specialty!

Call today for the financial security specialist in your area.

AMERICAN PHYSICIANS LIFE
Bates Drive, P.O. Box 281
Pickerington, Ohio 43147
Telephone (614) 864-3900
Toll-free in Ohio, 1-800-282-7515
Toll-free outside Ohio, 1-800-742-1275

Charles L. Bowers, MD
Bloomfield Hills

Charles L. Bowers, MD, Bloomfield Hills, died on April 26, 1984 at the age of 66. Doctor Bowers was a staff member of St. Joseph Mercy Hospital and a family physician in the Pontiac area for 32 years. He was medical director and chief of staff at the Bloomfield Hospital and Bloomfield Hills Sanitarium. Doctor Bowers graduated from the Wayne State University School of Medicine in 1951 and was an intern at St. Joseph for two years.

Benjamin Brand, MD
Farmington Hills

Benjamin Brand, MD, Farmington Hills, died on May 5 at the age of 80. He was the former chief of surgery at Brent General Hospital in Detroit. Doctor Brand, who was a general practitioner and surgeon, graduated from the University of Michigan Medical School. He was a physician for the Selective Service in World War II.

Andrew Y. Cho, MD
Bloomfield Hills

Andrew Y. Cho, MD, Bloomfield Hills, died on April 8. He was 49. Doctor Cho graduated from Catholic Medical College in Seoul. He completed his internship at St. Joseph Mercy Hospital in Detroit and his residency at St. Mary. He was a member of the Wayne State University faculty and a fellow of the American College of Pathologists.

Cecil W. Lepart, MD
Grosse Pointe

A former president of Detroit Medical Society, Cecil W. Lepart, MD, Grosse Pointe, died on April 11. He was 83. Doctor Lepart graduated from the University of Michigan Medical School in 1928 where he did his residency. He was appointed chief of ophthamology at the Children's Hospital and was also a professor of medicine at Wayne State University.

C. Rex Moe, MD
Kalamazoo

C. Rex Moe, MD, Kalamazoo, died on February 26 at the age of 73. Doctor Moe was affiliated with Borgess and Bronson hospitals in Kalamazoo. He was a graduate of the Unviersity of Michigan Medical School.

Peter F. Moser, MD
Flat Rock

Peter F. Moser, MD, Flat Rock, died on March 31. He was 71. Doctor Moser studied at the University of Frankfurt and the University of Munich before teaching at the University of Frankfurt. He came to the United States in 1953. Doctor Moser worked at Wyandotte Hospital before entering the Flat Rock Medical Center and then private

LABORATORY OF CLINICAL MEDICINE
MID-MICHIGAN REFERENCE LABORATORY, II, Inc.
(517) 372-8180

1322 E. Michigan Ave.
Suite 211
Lansing, Michigan 48912

930 E. Mt. Hope Ave.
Lansing, Michigan 48910

2909 E. Grand River Ave.
Suite 104
Lansing, Michigan 48912

W. E. Maldonado, M.D.
Director

Robert B. Foy, Ph.D.
Chief Executive Officer

Ann E. Chernys, M.D.
John W. Dyke, Ph.D.
Dennis E. Freer, Ph.D.
John J. Gillespie, M.D.
Ronald N. Horowitz, M.D.
John R. Kateley, Ph.D.

John J. Lyday, M.D.
Joseph R. Melvin, Ph.D.
Sandra K. Shirley, M.D.
Laurence R. Simson, Jr., M.D.
Susan M. Strate, M.D.
Irene K. Trombley, M.D.

LABORATORY OF CLINICAL MEDICINE
MID MICHIGAN REFERENCE LABORATORY

REFERENCE LABORATORY FOR SPECIALIZED PROCEDURES
Specimen Pickup and Delivery of Test Results Daily
House calls are available upon Physician's request
Assignment is accepted from Medicare, Medicaid, Blue Shield and all other insurance carriers.

practice. He retired in 1982 because of ill health.

Robert C. Rehner, MD
Kent City

Robert C. Rehner, MD, Kent City, died on May 17 at the age of 79. He was a graduate of the University of Michigan Medical School. Doctor Rehner was a member of the American Psychiatric Association and Michigan Society of Neurology and Psychiatry. He served in the Army from 1941 to 1946.

Philip A. Riley, Sr., MD
Jackson

Former speaker of the MSMS House of Delegates, Philip A. Riley, Sr., MD, Jackson, died on April 25. He was 87. He also was a past president of the Jackson County Medical Society and a founder and former member of the board of directors of Blue Shield of Michigan. Doctor Riley was a veteran of World War I and a member of the Knights of Columbus. He graduated from University of St. Louis School of Medicine. He practiced medicine in Jackson for more than 50 years.

Harry F. Vail, MD
Essexville

Harry F. Vail, MD, Essexville, died on April 29 at the age of 74. Doctor Vale graduated from the College of Medicine at the University of Illinois and served his internship at the former Mercy Hospital in Bay City. He entered the US Army Air Force where he served in the 11th Evacuation Hospital in Italy, France, and Germany, until his discharge in 1945. He was former president of the Bay County Medical Society and served as chief of staff at the General and Mercy hospitals.

Wilford C. Wood, MD
Detroit

Wilford C. Wood, MD, Detroit, died on March 24, at the age of 84. Doctor Wood opened his office in 1928 and continued working and making house calls until three weeks before his death. He was a graduate of Ohio State University Medical School and served his residency at Henry Ford Hospital. Doctor Wood also was medical director for the Detroit Police Department for 36 years.

HEALTH PROFESSIONALS!

The Army Medical Department represents the largest comprehensive system of health care in the United States and offers unique advantages to the student, resident, and practitioner in the following professions:

- Physician
- Dentist
- Veterinarian
- Optometrist
- Psychologist
- Nuclear Scientist
- Environmental Scientist
- Civil Engineer
- Podiatrist
- Audiologist
- Pharmacist
- Laboratory Scientist

As an Army Officer, you will receive substantial compensation, an annual paid vacation, and participate in a remarkable non-contributory retirement plan.

For more information just fill out the attached form and mail. Or call: (313) 668-2190/2191. (Collect calls accepted.)

PLEASE SEND MORE INFORMATION ABOUT OPPORTUNITIES
IN THE ARMY MEDICAL DEPARTMENT
MAIL OR CALL:
ARMY MEDICAL DEPT., PERSONNEL OFFICE, 200 E. LIBERTY ST.,
ANN ARBOR, MI 48107, PH: (313) 668-2190/2191

NAME ____________________ AGE ____
ADDRESS ____________________
ZIP ____________ PHONE (AC) ____________
SCHOOL ATTENDED/ATTENDING ____________
GRADUATION DATE ________ DEGREE ________
SPECIALTY AREA OF INTEREST ____________
____

The rate for each classified advertisement in *Michigan Medicine* is 20¢ per word, with a minimum charge of $10.00. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

Positions Open

FAMILY PRACTITIONER — Seeking associate to join a well established Family Practice Clinic with x-ray and laboratory facilities. Excellent opportunity to be part of an expanding practice located in a water recreational area northeast of Detroit. Call (313) 794-9331 ask for Barbara, or write c/o Box 406, Algonac.

PHYSICIAN OPPORTUNITIES. Bernie Hoffmann Associates, Inc. is currently assisting a major metropolitan Detroit health care provider in the expansion of their suburban clinic network. The search for qualified physicians includes the following specialties: Obstetrics and Gynecology, Emergency Medicine, Family Practice, Internal Medicine, Orthopedic Surgery and Pediatrics. The typical satellite center provides an excellent practice setting for a four person physician group. There are over 30 opportunities for board eligible or board certified physicians with available starting dates of 10/1/84, 1/1/85, and 7/1/85. A compensation program emphasizing flexibility and incentive will be explored with invited candidates. Interested physicians should submit curriculum vitae in confidence to: Tim Ignash, Senior Associate, Bernie Hoffmann Associates, Inc., One Northland Plaza, 20755 Greenfield, Suite 601, Southfield, 48075, (313) 557-9340.

CLINICAL DIRECTOR-BOARD CERTIFIED or eligible psychiatrists for inpatient psychiatric programs in southern and eastern Michigan. Administrative stipend plus opportunity for private practice with income potential in excess of $100,000. Other locations available nationwide for individuals willing to relocate. Send CV to: Personnel Recruiter, Dept. MI-1, Mental Health Management, Inc., 1500 Planning Research Drive, Suite 250, McLean, VA 22102.

MEDICAL DIRECTOR. OPPORTUNITY FOR PHYSICIAN with experience in medical group practice administration to join established HMO in Madison, Wisconsin. Group Health serves 29,000 patients with its staff of 20 physicians and total staff of 180. Excellent salary and benefit program. This represents a rewarding opportunity to develop or progress your career in medical administration. Contact: John Mueller, Group Health Cooperative, 1 South Park St., Madison, WI 53715; (608) 251-4156.

FAMILY PRACTICE. RAPIDLY EXPANDING STAFF MODEL HMO in Madison, Wisconsin, has opportunities for additional family practice physicians. Competitive salary with excellent benefits and attractive practice setting. GHC is an established, rapidly growing HMO serving 29,000 patients. Current staff totals 180 employees, including 20 physicians. Contact: John Mueller, Group Health Cooperative, 1 South Park St., Madison, WI 53715; (608) 251-4156.

OB/GYN. GROUP HEALTH COOPERATIVE has 1984 opening for Board certified/eligible obstetrician and gynecologist. GHC is an established, rapidly expanding HMO. Staff enjoy a stable salary plus excellent benefit program including 5-6 weeks of time off plus $3,000 CME funding. Madison is a city of 200,000 population; University of Wisconsin; and 4 lakes. Contact: John Mueller, Group Health Cooperative, 1 South Park St., Madison, WI 53715; (608) 251-4156.

FAMILY PRACTIONERS, GENERAL PRACTITIONERS OR EMERGENCY MEDICINE PHYSICIANS — with practice experience wanted for free-standing urgent care centers located in the Central Michigan area. Excellent access to recreational areas. Associate and Medical Director opening immediately. Other vacancies opening in August or September of 1984. Salary negotiable plus fringe benefits. Send C.V. to Contemporary Medical Management, Incorporated, 401 South Euclid Avenue, Bay City 48706 (517) 667-0494.

WANTED — PRIMARY CARE PHYSICIAN licensed in Indiana to practice in University 38-bed JCAH accredited hospital for a 12 month fiscal year appointment. Must be able to communicate with and have empathy toward the college age population. Salary negotiable; excellent fringe benefits. Send resume to T. A. Schott, Administrator, Purdue Student Hospital, West LaFayette, IN 47907.

MEDICAL RESIDENT IN SURGERY wanted to perform surgery to correct deformities, repair injuries, prevent diseases and improve function in patients under supervision of hospital staff; requires MD degree and one year training as a Resident in Surgery; 40 hours per week; $19,300 per year. Send resumes to 7310 Woodward Avenue, Room 415, Detroit 48202. Ref. No. 15184.

MEDICAL RESIDENT IN PSYCHIATRY wanted for diagnosis, treatment and patient care in all areas of psychiatry under supervision of hospital staff. Requires MD degree and one year medical residency; 40 hours per week; $20,806 per year. Send resumes to 7310 Woodward Avenue, Room 415, Detroit 48202. Ref. No. 15284.

KALAMAZOO, MICHIGAN — EXPERIENCED PHYSICIAN needed to head University Health Center Sports Medicine Clinic and work part time with eight other clinicians in the University Health Center. Sports Medicine experience necessary and administrative experience preferred. Malpractice coverage and excellent fringe benefits. Beautiful clinic on campus in well located civic minded city. Salary negotiable. Position open July 1, 1984. Contact: Donald T. McNally, Director, University Health Center, Western Michigan University, Kalamazoo 49008. Call collect: (616) 383-6003.

ENJOY THE BENEFITS OF MULTI-SPECIALTY PRACTICE. Attractive positions available in our Health Maintenance Organization in the specialties of: Internal Medicine, Family Practice, Pediatrics, and Psychiatry. Opportunities available in the Louisville and Lexington, Kentucky areas for qualified physicians. Competitive salary and excellent fringe benefit package. For further information, please contact: Robert A. Gormley, MD, Acting Medical Director, Health America, P.O. Box 34098, Louisville, KY 40232 (502) 456-8117.

BOARD CERTIFIED DIAGNOSTIC RADIOLOGIST for large radiology practice serving multiple office and hospital locations in northeast Ohio. The successful candidate should preferably have had 1-3 years post-residency experience either as a fellow or on staff. Remuneration, benefits, and vacation time are all excellent. Reply to Box 59, Michigan Medicine, 120 W. Saginaw, East Lansing 48823.

EXCELLENT OPPORTUNITY FOR A FULL-TIME licensed physician with industrial and private experience for a well established suburban clinic. Send replies to Box 60, Michigan Medicine, 120 W. Saginaw, East Lansing 48823.

PHYSICIANS NEEDED IN NORTH CENTRAL MICHIGAN — Family Practice, Urology, Pediatric and Orthopedic Surgery physicians needed in Grayling. This rapidly growing, beautiful resort area with a service population of approximately 40,000 has a 90 bed acute care hospital with attached 40 bed long term care unit. Family Practice, Internal Medicine, OB/GYN, Orthopedic Surgery and General Surgery physicians practice here at present (with several consulting specialists). Financial assistance is negotiable. Some opportunities exist within established practices. Well-established churches, country club, 34 miles of cross country ski trails, 200 miles of unrestricted waters for trout fishing, 200,000 acres of natural open country for snowmobiling and two major ski and winter sports areas 55 miles from Traverse City. Interested physicians, please send CV or call Barbara Lester, Mercy Hospital, 1100 Michigan Avenue, Grayling, 49738, (517) 348-5461.

GENERAL SURGEON, BOARD CERTIFIED or eligible, to join several doctor family practice Clinic in Cloquet, Minnesota, a community of 12,000 (30,000 service area) located 20 minutes from Duluth-Superior. Clinic facility is located one block from modern, well equipped 77 bed hospital. Cloquet enjoys a stable economy (forest products). Additionally, our community is noted for its excellent school system. First year salary guarantee, paid malpractice, health and disability insurance, vacation and study time. Contact John Turonie, Administrator, Raiter Clinic, Ltd., 417 Skyline Blvd., Cloquet, MN 55720. Telephone (218) 879-1271.

MICHIGAN TECHNOLOGICAL UNIVERSITY HEALTH SERVICE seeks a replacement primary care physician. The health facility is a medically oriented, ambulatory service, servicing a university student population of 7,500. Annual student visits are approximately 12,000. Liberal fringes, meeting allowance, and vacation benefits complement a competitive salary and allow adequate enjoyment of the rural all-season recreation area. Contact David Schwalm, PA-C, Administrator, Michigan Technological University Health Service, Houghton, 49931, or call (906) 487-2435. Michigan Technological University is an Equal Opportunity Educational Institution/Equal Opportunity Employer.

OPERATING CORPORATION OF SEVERAL MEDICAL CENTERS providing primary care for senior citizens seeks Board Certified or Board Eligible, Florida licensed MDs with the following specialties . . . Family Practice, Internist, Cardiologist and Radiologist. Salary plus incentive. Insurances paid. Association fees paid. Contact Mr. Ed Hoke, H.S.C. Medical Centers, 1529 US 19 South, Levitz Center, Clearwater, FL 33546. Phone (813) 530-9455.

GASTROENTEROLOGIST — NEUROLOGIST — NEUROSURGEON: Independent group of private practitioners searching for an independent-practice oriented BC/BE gastroenterologist, neurologist, and neurosurgeon. Referral base includes 100 physicians, serving a population of 120,000. Unlimited recreational activities, medium sized university city. Immediate need. Chippewa Valley Independent Physicians, P.O. Box 1725, Eau Claire, Wisconsin 54702.

POSITIONS WITH THE STATE OF MICHIGAN

— Currently taking applications for positions expected to be available in the future. Office locations now include Kalamazoo, Lansing, Southfield, and Traverse City. A board certified or board eligible psychiatrist needed for the Kalamazoo office, and internists with rheumatology or cardiology background desired for other offices. Beginning salary in low 60s with approximately 26% fringe benefits. An equal opportunity employer. All inquiries treated confidentially. For further details, please write: Harry D. Nesmith, MD, Chief Medical Consultant, Disability Determination Service, PO Box 30011, Lansing, 48909.

FAMILY PHYSICIAN: IMMEDIATE OPENING for a residency trained FP preferring small-town life style and interested in "whole person medicine from the Christian perspective" in a new office in the small college town of Hillsdale in southern Michigan. Write or call: Frederick L. Bean, MD, Hillsdale Family Practice, 111 South Howell, Hillsdale, 49242.

Positions Wanted

OPTOMETRIST WITH 7 YEARS EXPERIENCE in private and HMO-type optometric practice desires opportunity to work full or part time in a private practice of ophthalmology or HMO-type practice affiliated with ophthalmology. Prefer Detroit metropolitan area. Well-skilled clinician in optometric care with primary interest in contact lenses. Versed in automated subjective refraction and fundus photography. William L. Park, OD, 5335 Inverrary Lane, Milford, 48042, (313) 684-5678.

OPHTHALMOLOGIST AVAILABLE for locum tenens. Board certified. Also interested in full-time or part-time position. Contact: Box 39, Michigan Medicine, 120 W. Saginaw, East Lansing 48823.

Miscellaneous

FOR SALE: A VERY PRODUCTIVE medical Practice located in two offices — 22 miles apart — east of Flint, Michigan in mid-thumb area. Total Gross Corporate Income $197,000 with corporate expenses being 46%. Excellent hospital in one of the communities. Now working half day in each office 6 days per week. Desires to retire. Asking price of the Medical Practice will be discussed in person if interested, but a small down payment will be required and the balance can be financed over a period of 10 years at 10% interest. Respond to: Box 61, Michigan Medicine, 120 W. Saginaw, East Lansing 48823.

BEFORE OR AFTER THE COLLER, Pemberthy, Thirlby Seminar — Houseboat vacations on beautiful Lake Charlevoix — or — Chain of Lakes, Elk Lake, Torch, Etc. Featuring 40 foot twin I/O powered River Queens of durable steel, proven design. All the features of a luxury motor home — and more! Families or couples — sleeps 6-8. Brochure, North West Marine, 202 Ferry Ave., Charlevoix 49720. (616) 547-6343. For Chain of Lakes, Elk River Marina, Elk Rapids, 49629, (616) 264-9500. Or — NWM Houseboat Vacations, 10049 Grand View Ct., Traverse City, (616) 947-1946.

FOR SALE. MARCO ISLAND CONDOMINIUM, high-rise, on the beach. Beautiful Gulf of Mexico view and island view. Two bedroom — two and one-half baths — approximately 2000 square feet. All amenities. For the discriminating buyer. Decorator furnished. Call area (313) 651-3871.

MICHIGAN: PRACTICE OPPORTUNITIES NOW AVAILABLE. Immediate income from well established practice, malpractice insurance, fully equipped office, with a congenial staff. Excellent opportunity for ambitious physician. For more information contact: Emergency Consultants, Inc., One Windemere Place, Petoskey 49770; 1-800-253-7092 or in Michigan 1-800-632-9650.

KIAWAH ISLAND, WILD DUNES BEACH and Racquet Club, Charleston, S.C. resorts. Choice 1-4 Bedroom Villas for rent. In prime locations, including ocean front. 25% owner discount. Brochure. (803) 556-6353.

LAKE SUPERIOR RETREAT. EAGLE HARBOR, MI. Two bedroom home for seasonal recreation or retirement. Fireplace, laundry, garage. Spectacular view. For additional information regarding this or other properties in Houghton and Keweenaw County, contact Mary Keozior, Douglass Real Estate. (906) 482-8880, 324 Shelden, Houghton 49931.

SPORTFISHING CHARTERS AVAILABLE for salmon (Lake Michigan, Ludington and Frankfort) and walleye (Lake Erie, Monroe), aboard a 28 ′ Bertram cruiser. All tackle provided. For details, call 1-313-625-2730.

PRACTICES WANTED — We have qualified purchasers looking to assume established MD, DO and DDS practices in Metro area. All inquiries confidential. Call Commonwealth Real Estate Group (313) 288-0022.

HEALTH FORCES SALE OF ACTIVE GENERAL Practice in Detroit. Grossing over $300,000. Call Commonwealth Real Estate Group, (313) 288-0022.

MEDICAL PRACTICE FOR SALE. Downtown Detroit area. Call Commonwealth Real Estate Group, (313) 288-0022.

WE HAVE QUALIFIED PURCHASERS LOOKING to purchase Nursing Homes in Michigan. All inquiries confidential. Call Commonwealth Real Estate Group, (313) 288-0022.

ACTIVE MEDICAL PRACTICE FOR SALE. Detroit Area. Grossing $200,000. Call Commonwealth Real Estate Group, (313) 288-0022.

MEDICAL PRACTICE FOR SALE. Located near Traverse City area. Doctor planning retirement. Call Commonwealth Real Estate Group, (313) 288-0022.

INCOME PRODUCING INVESTMENT FOR SALE. Prestigious 18,000 sq. ft. office building, fully leased. Near 11 Mile and Lahser. $684,000. Terms considered. Call Commonwealth Real Estate Group, (313) 288-0022.

MEDICAL OFFICE SPACE AVAILABLE the end of 1984. 2600 sq. feet of office space with shared waiting room. Linden Bristol Square, 5119 W. Bristol Road, Flint 48554. (313) 732-1620.

BIG TWIN LAKE, KALKASKA COUNTY — Custom ranch, 2000 sq. ft. luxury living. Features include wet bar, recreation room, fireplace, cedar walk-in closets, 3 bedrooms, 2½ baths, large deck area, 100 ft. sugar sand beach and much more. For sale by owner. Priced at $125,000.00. Phone (616) 587-8238.

Rx PADS PRINTED to your specifications. $20.00 per thousand in pads of 100. $21.00 one time set up charge. Shipping additional. Small Craft Printing Company, 211 E. Kalamazoo St., Lansing, 48933 (517) 485-0553.

PREVIOUSLY OWNED MEDICAL LABORATORY AND OFFICE EQUIPMENT available in excellent condition. We buy, sell, trade, move and repair. Office assessments available by certified surgical consultants. Call Doctor Medical Resale, Ltd. (313) 569-4407, 9 AM to 9 PM.

DOCTOR, YOU CAN'T BEAT THE QUALITY OR THE PRICE! Holter Monitor scanning service. Physician owned, trained and supervised. $35.00 for cassette reports; $45.00 for reel to reel reports; no contracts to sign. We can arrange for lease/purchase of Holter equipment. Why are you paying more and getting less? DCG Interpretation (313) 879-8860.

ATTENTION DOCTORS: We have previously owned medical, laboratory, office and x-ray equipment in excellent condition. We buy, sell, trade, move and repair. Office appraisals available by certified surgical consultants. Call Doctor Medical Resale at 313-569-4407, 9 AM-9 PM.

PHYSICIAN SIGNATURE LOANS TO $50,000. Up to 7 years to repay. No repayment penalties. Prompt, courteous service. Competitive fixed rate, with no points, fees or charges of any kind. Physicians Service Association, Atlanta, GA. Toll-free (800) 241-6905.

Thanks to our advertisers

AMRC	355
American Physicians Life	371
Blue Cross/Blue Shield	361
Birmingham Motors Ltd.	IFC
Winthrop Breon	341-342
Brown Pharmaceutical Company	337
Burroughs Wellcome	347
HASCO	345
Health Care News	364
Inland Steel Company	363
Institute for Health Maintenance	339
Stanley H. Kaplan	363
Lab of Clinical Medicine	372
Eli Lilly	351
MPMLC	352-353
Marion Lab	367-368
Medical Protective Company	346
PICOM	343
Pfizer Lab	356-357
Professional Practice Sales	363
Roche Lab	IBC-BC
Stratton-Cheeseman	365
US Army	373
Upjohn Company	358
Woodside Capital Corp.	354
Worldwide Financial Seminars	362

Are organized medical staffs really necessary?

Hospital medical staff issues rapidly are becoming of great concern to physicians. In recognition of this, the American Medical Association last year created a Hospital Medical Staff Section. This section quickly has become a vital and dynamic force within the Association. It has helped the AMA deal more effectively with issues raised by the unique relationship between physicians' hospital medical staff organizations and hospital trustees and their administrators.

The Michigan State Medical Society, also recognizing the growing complexities of physicians' relationships with their hospitals, has likewise established an MSMS Hospital Medical Staff Section. This section, with representation from every hospital medical staff in Michigan, will meet several times each year. The section will have the full resources of MSMS and the AMA.

The creation of hospital medical staff sections reflects physicians' growing concern over a national trend for hospital trustees to assume they are the sole and final authority on all hospital matters. In the past we were all reasonably comfortable in accepting the trustees' responsibility for the physical plant, for fiscal matters, and for representing the views and concerns of the community. At the same time it was generally conceded that only physicians could evaluate and pass on the training and competency of other physicians. It also seemed appropriate for the medical staff to elect its own officers. These basic assumptions, unfortunately, no longer are universally accepted by the hospital community, and in many settings confrontation has replaced cooperation.

Louis R. Zako, MD
MSMS President

One of the factors leading to the present confrontational scene is the composition of the board of trustees, particularly in urban areas. Almost all of the trustees are lay people, overwhelmingly white males, often not living in the community where the hospital is located, and generally appointed to the board because they ostensibly know how to run a bank or a manufacturing company. Rarely are physicians appointed to the board, except grudgingly, and then often without a vote.

Both trustees and administrators generally bring a business orientation to their deliberations and tend more and more to run the hospital as a pure business, often substituting marketing for excellence and compassion in patient care.

I'm not being critical of trustees collectively, a majority of whom are conscientiously carrying out their duties, usually with little or no financial remuneration. I am, however, expressing a concern over a social trend which is potentially detrimental to the quality of patient care and the maintenance of independent medical judgment if this trend is not modified or reversed.

Who speaks for the patient when hospital trustees and administrators use language like "marketing," "demographics," "market share," "market penetration," and are busily creating for-profit subsidiaries while condemning proprietary or for-profit hospitals, which they accuse of "skimming?"

Are organized hospital medical staffs REALLY necessary? Probably not, unless we physicians significantly change our attitudes about our rights and responsibilities. If the medical staff is simply a conduit for or an instrument of the board of trustees and the board of trustees is the only legal and ethical advocate for the patient, why pay medical staff dues and go through the charade of an organized staff? Further, why go through the charade of electing our chief of staff and other medical staff officers, when they are paid by the hospital?

It saddens me to observe time and again the submissiveness and resignation of the medical staff whenever there is a confrontation. I get tired of hearing my colleagues citing legal precedence for the trustees' authority in all matters, when courts change their mind every day, and when laws are made, amended, and repealed according to the dictates of what society considers appropriate behavior.

We owe it to our patients to re-assert the rights and responsibilities of the medical staff. The newly-created Hospital Medical Staff Section of MSMS and its national counterpart at the AMA most definitely can help us with that challenge. We have an obligation to our patients separate and distinct from the trustees, and we must not abdicate that obligation.

COMPLETE LABORATORY DOCUMENTATION[1-5]... EXTENSIVE CLINICAL PROOF

FOR THE PREDICTABILITY CONFIRMED BY EXPERIENCE

DALMANE® CIV
flurazepam HCl/Roche

THE COMPLETE HYPNOTIC PROVIDES ALL THESE BENEFITS:

- Rapid sleep onset[1-6]
- More total sleep time[1-6]
- Undiminished efficacy for at least 28 consecutive nights[2-4]
- Patients usually awake rested and refreshed[7-9]
- Avoids causing early awakenings or rebound insomnia after discontinuation of therapy[2,5,10-12]

Caution patients about driving, operating hazardous machinery or drinking alcohol during therapy. Limit dose to 15 mg in elderly or debilitated patients. Contraindicated during pregnancy.

DALMANE® CIV
flurazepam HCl/Roche

References: **1.** Kales J *et al*: *Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A *et al*: *Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A *et al*: *Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A *et al*: *Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol 3*:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **9.** Amrein R *et al*: *Drugs Exp Clin Res 9*(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol 3*:303-326, May 1981. **11.** Greenblatt DJ *et al*: *Sleep 5*(Suppl 1):S18-S27, 1982. **12.** Kales A *et al*: *Pharmacology 26*:121-137, 1983.

DALMANE® CIV
flurazepam HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

DOCUMENTED IN THE SLEEP LABORATORY[1-5]...

PROVEN IN THE PATIENT'S HOME

FOR A COMPLETE NIGHT'S SLEEP

DALMANE® (IV)

flurazepam HCl/Roche

STANDS APART

15-MG/30-MG CAPSULES

See preceding page for references and summary of product information.

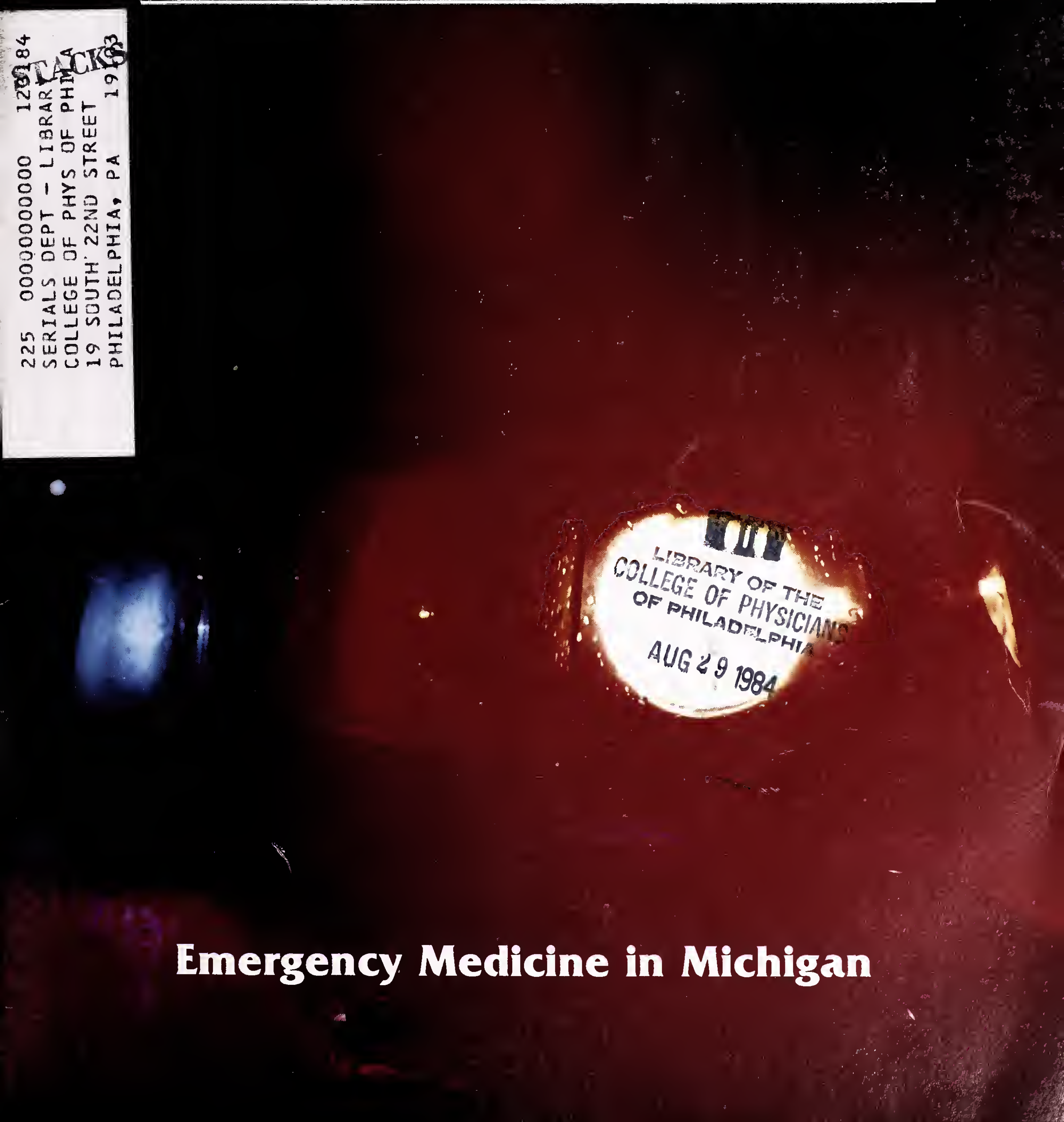
Copyright © 1984 by Roche Products Inc. All rights reserved.

MICHIGAN MEDICINE

August 1984 The award-winning JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Vol. 83, No. 37

225 0000000000 12/84
SERIALS DEPT - LIBRARY
COLLEGE OF PHYS OF PHILA
19 SOUTH 22ND STREET
PHILADELPHIA, PA 19103

STACKS



LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA
AUG 29 1984

Emergency Medicine in Michigan

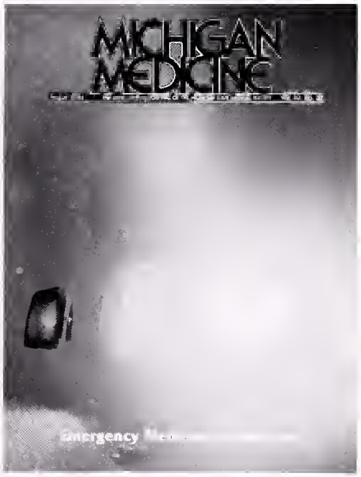
The Art of Medicine

Medicine — the helping science, the healing art. The 1984 MSMS Annual Scientific Meeting offers you the opportunity to choose from 55 CME courses that promote clinical medicine. Join your colleagues and earn up to 18 hours of Category I Credit while you enhance your "art."

1984 MSMS ANNUAL
SCIENTIFIC MEETING
November 13, 14, 15, 1984
Hyatt Regency Dearborn

August 1984, Vol. 83, No. 37

MICHIGAN MEDICINE



About the cover:

Our photo this month spotlights emergency medicine, the focus of our special report, beginning on page 380. Photo by Kim Kauffman.

Special report

380 Emergency medicine is a vital member of the family of Michigan medical specialties. If physicians work together to ensure healthy emergency departments in their hospitals, they can improve the use of all medical services, suggests one of our authors. With Emergency Medicine Week declared for the dates of Sept. 16-22, we examine the status of emergency medicine and its role in relation to other medical specialties. Please read on for details; Michael D. Levine, MD, and Dennis C. Whitehead, MD

Features

390 Prominent Michigan physician Vivian Lewis, MD, says medical practice for women today is ‘a piece of cake,’ compared with conditions of previous years; Willah Weddon

392 1984 MSMS Annual Scientific meeting will bring an up-to-date, stimulating array of Category I courses to Michigan physicians

393 Category I CME self study article and quiz: Osteoporosis; Joan C. Stryker, MD

398 Meet Louis R. Zako, MD, MSMS president, family physician, politician, teacher, runner

Departments

379 Letters

388 MSMS/A; Nancy Crandall

407 News; Joyce Crum

408 New MSMS members

414 Category I courses

417 Deaths

420 Meetings

422 Classified ads

423 Ad Index

424 President’s page; Louis R. Zako, MD

Next month in *Michigan Medicine:*
All the details about the 55 Category I half-day CME courses offered at the coming 1984 MSMS Annual Scientific Meeting. *Michigan Medicine* will describe titles of the courses, what will be discussed, course directors and their professional positions, speakers and their qualifications. In addition, members may register for the program and make housing reservations with materials included in the September issue.

Michigan State Medical Society

President	Louis R. Zako, MD, Dearborn Heights
President-elect	Richard J. McMurray, MD, Flint
Immediate Past President	Donald K. Crandall, MD, Muskegon
Secretary	Robert M. Leitch, MD, Battle Creek
Treasurer	Leland E. Holly, II, MD, Muskegon
Speaker	Gerald H. Mandell, MD, Detroit
Vice Speaker	Robert D. Burton, MD, Grand Rapids
AMA Delegation Rep.	Richard J. McMurray, MD, Flint

Board of Directors

Chairman	Thomas R. Berglund, MD, Portage
Vice Chairman	Carl A. Gagliardi, MD, Dearborn

District directors

District 1	Carl A. Gagliardi, MD, Dearborn
	James J. Humes, MD, Detroit
	Kenneth J. Ray, MD, Trenton
	Henry M. Domzalski, MD, Detroit
	Arthur A. Ulmer, MD, Grosse Pointe Shores
	Frank B. Walker, MD, Grosse Pointe Farms
District 2	Justin L. Sleight, MD, Lansing
District 3	William D. Walters, MD, Battle Creek
District 4	Thomas R. Berglund, MD, Portage
District 5	Harvey M. Andre, MD, Grand Rapids
	Kornelius Van Goor, MD, Grand Rapids
District 6	Richard L. Rapport, MD, Flint
District 7	Kenneth B. Herrington, MD, Bad Axe
District 8	Jack L. Barry, MD, Saginaw
District 9	Vickers C. Hansen, MD, Manistee
District 10	Charles L. Oppy, MD, Roscommon
District 11	Robert E. Paxton, MD, Fremont
District 12	Carl Hammerstrom, MD, Marquette
District 13	Kenneth E. Rowe, MD, Hancock
District 14	Marguerite Shearer, MD, Ann Arbor
District 15	Billy Ben Baumann, MD, Pontiac
	Frederick W. Bryant, MD, Royal Oak
	Joel W. Clay, MD, Mt. Clemens

Michigan State Medical Society
Warren F. Tryloff, director

Committee on Publications
Harvey Andre, MD, Grand Rapids, chairman
Frederick W. Bryant, MD, Royal Oak
Vickers C. Hansen, MD, Manistee
Leland E. Holly II, MD, Muskegon
Richard L. Rapport, MD, Flint
Marguerite Shearer, MD, Dexter
Louis R. Zako, MD, Dearborn Heights

Editor
Judith Marr

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

MICHIGAN MEDICINE (ISSN 0026-2293) is the official journal of the Michigan State Medical Society, published under the direction of the Publications Committee. Published five times a month, 60 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $30.00; single copies, $1.50. Additional postage: Canada, $1 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to articles, news, exchanges, should be addressed to Judith Marr, advertising inquiries to Joyce Crum and address changes to Peg Berry, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517-337-1351.

©1984 Michigan State Medical Society

'Outstanding doctor'

The following letter was received recently at MSMS headquarters:

At a time when mediocrity breeds mediocrity, it is reassuring to know there are still those who rise above the norm in the performance of their occupation.

Doctor Dong-Soo Kim, Howell, is just such a person. A dedicated pediatrician, he combines medical professionalism with sincere affection towards his patients. A listening ear, a kind word, a hug, are dispensed as freely as his medical expertise.

It is specifically his medical expertise that we address today.

Our daughter, Katherine, became a patient of Doctor Kim's upon her birth, March 13, 1984. Although Katherine was perfectly formed to the naked eye, the professional touch of Doctor Kim's revealed a dislocated leg. Instructions for triple-diapering were carried out immediately by the staff at McPherson Community Health Center.

An informative and reassuring conversation was held between Doctor Kim, my husband and myself regarding Katherine's condition.

A thoughtful follow-up visit to me was made to reinforce his optimistic views on recovery.

Arrangements with a bone specialist were made by Doctor Kim prior to our discharge from McPherson. At that visit we learned the best key to recovery is early detection. A leg dislocation could require braces, body casts or surgery, if left undetected or diagnosed at a later date.

It's been eight weeks now and x-rays reveal Katherine's leg is well on the mend.

We are still using multiple diapers as the only aid to healing and feel confident of a great report at Katherine's follow-up visit to the specialist in July.

Needless to say, we are thankful Doctor Kim has made Livingston County his area of practice and, specifically, our children among his patients.

We want to express our gratitude to Doctor Kim.

Concurrently, we wish to advise the medical society that Doctor Kim is an outstanding doctor and a fine human being.

Sandra and John Moe
Howell

First place

Congratulations on your first prize from Sandoz Pharmaceuticals. You do have elegant covers, as well as superb contents. Keep up the good work.

Miriam Polich
Executive Vice President
State Journal Group
Oak Park, IL

Congratulations on your recent award for excellence in medical journalism! Your first prize is wonderful.

I am writing to ask if you could add my name to your mailing list for *Michigan Medicine*. I would very much like to receive your publication.

Jan Monaco, MHS
Executive Director
Spokane County
Medical Society
Spokane, WA

Congratulations on receiving first prize in the Sandoz Medical Journalism Competition. We are interested in getting on your mailing list.

Do you participate in complimentary subscription exchanges? Please let me know how we can start receiving copies of *Michigan Medicine*.

Karen Cason Murphy, Editor
Private Practice
Oklahoma City

Congratulations on your recent award from Sandoz Pharmaceuticals for the best state medical publication.

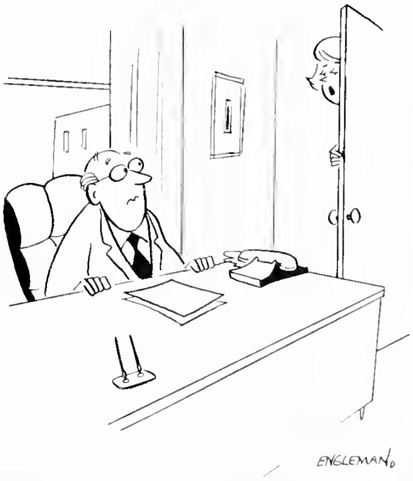
It is said you should always learn from the best so I would greatly appreciate receiving a past issue of your magazine for my information and edification. I am enclosing a copy of our monthly publication which goes to approximately 2,200 physicians in Western New York.

Congratulations again on your award.

James E. Kelly, Editor
Medical Society of the
County of Erie
Buffalo, NY

Have been going to write and congratulate you on winning again with *Michigan Medicine!* Also to tell you I won a first place in the Michigan Press Women's communication contest this year with the story about the "Flying Docs" ("Physicians in flight," page 313, May, 1983, *Michigan Medicine*). Haven't heard how it fared in national competition.

Willah Weddon
Stockbridge



"Sixty minutes is here to see you, doctor!"

By Michael D. Levine, MD

Emergency Medicine: The twenty-third specialty

"There is no stopping an idea whose time has come."

The first board examination given by the American Board of Emergency Medicine (ABEM) was administered audaciously five months from the time emergency medicine was recognized as the twenty-third specialty. The research and development of this examination covered a five year period at a cost of over $500,000.

Residency training programs in emergency medicine began nine years prior to specialty status recognition. Thousands of physicians boldly chose to dedicate their careers to a specialty that did not exist in the ledgers of organized medicine.

Never before have public interest and demand, changes in practice style, federal legislation (EMS Systems Act of 1973), and technologic advances coalesced to form an entity able to move through the system as rapidly en route to formal recognition.

In September 1979, 11 years after the Charter Meeting held at the Lansing Holiday Inn, Emergency Medicine became a specialty.

The emotional labels (boldness and audacity) which may be attributed to innovation within an established system tend to dissipate when the advantages of the innovation become apparent. Such will be the case with the Michigan-born American College of Emergency Physicians now encompassing over 11,300 members with chapters in all states.

The uniqueness of this specialty can only be appreciated through understanding the elements that comprise its essence, and lend marked differences from traditional medical practice.

The emergency department functions every hour of every day of the year. Most emergency departments utilize triage systems and teams comprised of nurses and ancillary personnel (EMT's, PA's etc.) with expanded roles, who assess patients upon initial presentation and manage the flow of the patient from initial history gathering to final discharge instructions. The laboratory and x-ray turnover times may vary significantly during the time periods when the "in-house" testing is being performed. The availability of on-site radiologists to read films accurately significantly alters the amount of work needed to process the same patient through the system at different times of the day. Obviously the multiple injured patient who needs extensive x-rays requires a greater disposition time if the emergency physicians must interpret their own films.

The patient *volume* and *acuity level* will affect the flow of the patient through the department. The lack of predictability of these elements presents a difficult and frustrating challenge when attempting to establish staffing needs.

Risk factors abound in all areas of medical practice. Specific to the emergency department are

---

Doctor Levine, of Pontiac, is chairman, Publications Committee, Michigan Chapter, American College of Emergency Physicians. He is an attending physician, Department of Emergency Medicine, Crittenton Hospital, Rochester.

Emergency
MEDICINE WEEK
SEPT. 16-22, 1984

"Emergency departments admit between 15 and 30 percent of patients seen . . . (and) no patient goes through the emergency department experience without telling six to 10 people about it."

the lack of primary knowledge of the patient, need to rely upon historical elements which may be incomplete or inaccurate, questionable compliance and understanding on the part of the patient, the need for radio medical control to paramedics in the field, as well as lab, EKG, and x-ray interpretation by the emergency physician.

Many patients are not certain about prior maladies, present medications, or specific medication allergies. Some rely heavily upon the belief that their "case history" will be available immediately upon arrival. Documentation is vitally important, yet the demands of patient volume too frequently result in insufficient time for optimal charting.

In no other arena can a well documented chart be more of a friend, due to the human inability to remember the average patient seen once four years ago.

What is the magic of Emergency Medicine? A tremendous amount of humanity presents to the emergency department for a myriad of reasons. The caring skills needed by the emergency physician involve the need to competently care for all ages, all sexes (male, female, 'other'), all socioeconomic levels, and all levels of intellect and presumed intellect, in a calm, reassuring, sensitive manner, while undertaking multiple patient workups simultaneously.

One must be able to predict which overdose was really only gestural, which child really is clumsy and which may be abused, and which elements of a history may not be true. Treatment must be correct for the individual with superficial abrasion and also for the major chest trauma patient. It is here that we encounter persons who are not sexually active yet have rupturing ectopic pregnancies, drug and alcohol abusers presenting for definitive treatment *again,* and persons seeking work excuses or care for non-acute problems, all alongside the critically ill.

A successfully managed department will provide appropriate care, act as an entry point to the hospital's health care system, provide significant inpatient bed days, increase use of ancillary departments, and coordinate EMS, physician, and paraprofessional training and education.

Management of this department is best performed by a physician director who has the support of the hospital administration and the physician group. The director's responsibilities include business management, quality assurance, interaction with all hospital departments and administration, complaint management, CME availability, teaching, and others. The emergency department team will only succeed if all members participate and share the responsibilities.

The future

Over 1,000 hospitals across the country have closed their doors permanently during the last decade, and an additional 1,000 expect to do the same.

Changing populations, community standards, need for fiscal accountability after the previously enjoyed latitude, and duplication of services will all contribute. The hospital with a functional emergency department that provides competent care and can convert the patient to a *user of the hospital system* will succeed.

Marketing is a reality of today's successful practice. Emergency departments admit between 15 percent and 30 percent of patients seen, depending upon locale. No patient goes through the emergency department experience without telling six to 10 people about it. If your emergency department sees 25,000 visits per year, the pleasant treatment and competent skills, *or* the six hour wait are conveyed to a potential 250,000 persons.

Obviously, the strongest marketing format will spend time and dollars improving the emergency department product and the *patients' perceptions* of the events.

Despite the technological advances and consumer expectations, it still will be *common sense* decisions and *interpersonal skills* that allow the success of the doctor-patient relationship. Settings and structures will be modified by the times and the "alphabet soup" now on the horizon (HMOs, PPOs, PPGs, TEFRA-1, etc.), but there is no technological substitute for the art of medicine.

Despite the "problems" of the territory, emergency medicine has become popular for reasons such as:

1. The ability to start a practice without the immediate expenses of an office;
2. The constant variation — no two days are alike;
3. The opportunity to guide people with little knowledge of the health care system to appropriate modalities of care;
4. The gratification of being able to definitely diagnose and treat many illnesses and injuries;
5. The intensity of dealing with life and death situations and the satisfaction a good result brings; and
6. The ability to call one's time away from the emergency department truly free and unencumbered.

Thus emergency medicine has consistently been in the top three choices for specialty training. Emergency physicians develop and perform academic research activities and the ACEP recently has established and funded research fellowships. Emergency medicine has rapidly evolved in changing times for organized medicine and will continue to do so.

(A bibliography is available from the author.)

EMS in Michigan

By Dennis C. Whitehead, MD, FACEP

"In 1969 I gave a talk about emergency medical services to a group of physicians from around the UP," recalls David Gilbert, MD. "Most ambulances in the state were operated by funeral homes then. I pointed out the need to raise the level of training for field personnel so we could cut down on needless pre-hospital deaths. To my surprise, the response from the audience was less than enthusiastic. There was a lot of skepticism which I knew would be hard to overcome."

Doctor Gilbert, a surgeon at Calumet Public Hospital in the Keweenaw Peninsula, is not a man easily daunted. He spearheaded an effort to phase funeral homes out of the ambulance business. Later that year Houghton County's morticians signed agreements to that effect. Guidelines from the American College of Orthopedic Surgeons were adopted for training ambulance personnel. As care improved, public interest quickened.

Doctor Gilbert began to think bigger.

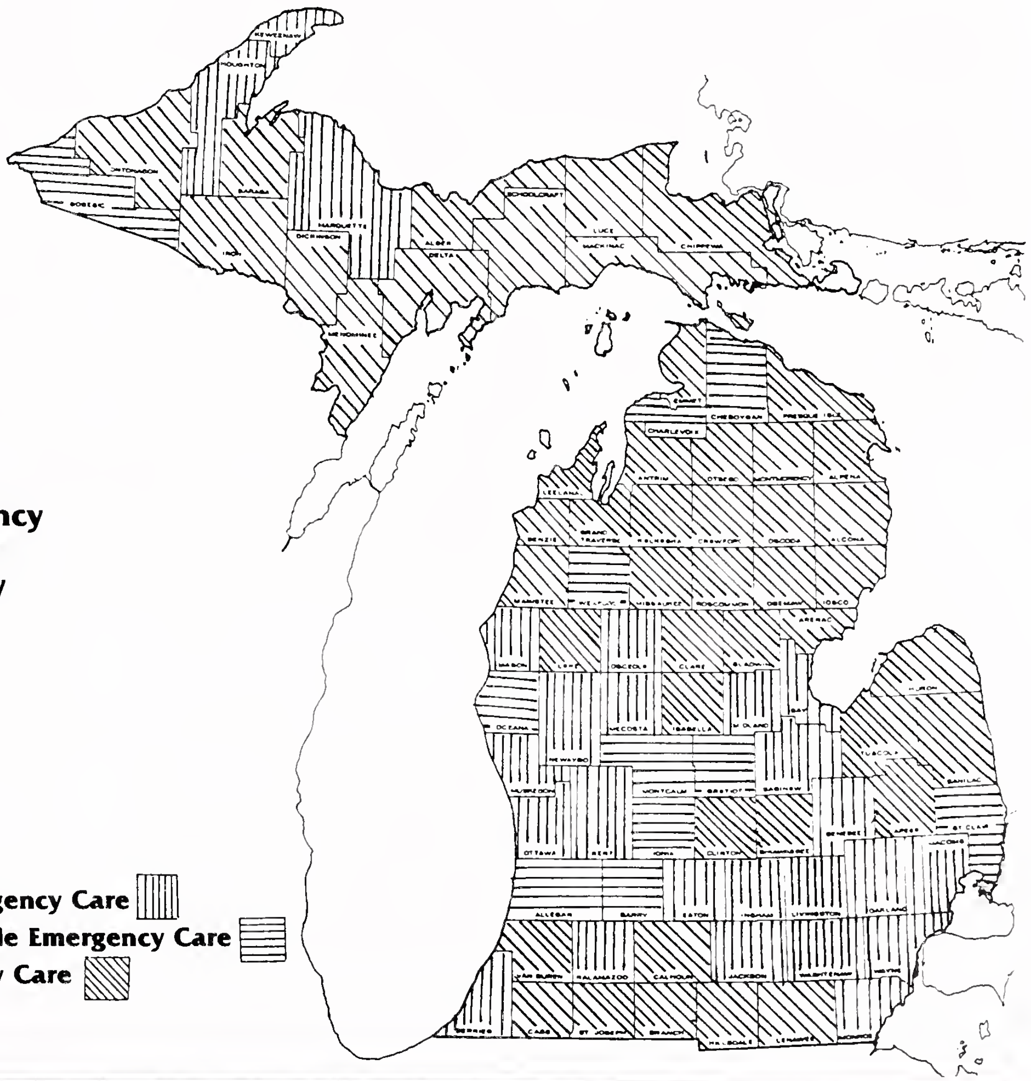
"In 1973 I picked six of our guys for additional training," he recalls, "but I didn't exactly tell them what I had in mind. At first it was all my own concoction, using medical and nursing texts. But soon, specialized course books came out and we followed them. A grant from the Michigan Association of Regional Medical Programs helped keep their studies going.

"About the time they started asking just what all this training was leading to, I had them educated to what we now call the AEMT level."

In 1975, the Michigan Department of Public Health granted the

---

Doctor Whitehead, of Marquette, is chairman, EMS Committee, Michigan Chapter, American College of Emergency Physicians.


KEWEENAW
HOUGHTON
ONTONAGON
GOGEBIC
BARAGA
MARQUETTE
DICKINSON
IRON
ALGER
DELTA
MENOMINEE
SCHOOLCRAFT
LUCE
MACKINAC
CHIPPEWA
EMMET
CHEBOYGAN
PRESQUE ISLE
CHARLEVOIX
ANTRIM
OTSEGO
MONTMORENCY
ALPENA
LEELANAU
BENZIE
GRAND TRAVERSE
KALKASKA
CRAWFORD
OSCODA
ALCONA
MANISTEE
WEXFORD
MISSAUKEE
ROSCOMMON
OGEMAW
IOSCO
ARENAC
MASON
LAKE
OSCEOLA
CLARE
GLADWIN
BAY
HURON
OCEANA
NEWAYGO
MECOSTA
ISABELLA
MIDLAND
TUSCOLA
SANILAC
MUSKEGON
MONTCALM
GRATIOT
SAGINAW
OTTAWA
KENT
IONIA
CLINTON
SHIAWASSEE
GENESEE
LAPEER
ST CLAIR
MACOMB
ALLEGAN
BARRY
EATON
INGHAM
LIVINGSTON
OAKLAND
VAN BUREN
KALAMAZOO
CALHOUN
JACKSON
WASHTENAW
WAYNE
BERRIEN
CASS
ST JOSEPH
BRANCH
HILLSDALE
LENAWEE
MONROE

Levels of emergency services available in Michigan today

KEY

Advanced Mobile Emergency Care ▥

Limited Advanced Mobile Emergency Care ▤

Basic Mobile Emergency Care ▧

first Advanced Life Support license to Doctor Gilbert's "guinea pigs" at Mercy Ambulance in Calumet.

"By today's standards, it was pretty much a low key thing," smiles Doctor Gilbert. "I wanted to see if it could be done. My catchword was 'You shall be able to.'

"We surmounted a lot of obstacles: Michigan's worst economy, worst weather, worst terrain, and worst radio transmissions due to our mineral deposits. But it was gratifying to see the skeptics jump on our bandwagon when they saw our results.

"Sometimes I still can't believe we pulled it off. I'd like to think our successful experiment inspired others to give it a try."

The ACEP

John Wiegenstein, MD, had a busy general practice in Lansing in the 1960's. Too busy. "In 1967, my parents came to visit me one weekend, the first time I had seen them in quite a while. Naturally the phone rang off the hook constantly, and I was either at the hospital or out on house calls nearly the whole time they were here. I don't think I spent more than 15 minutes with them before they had to leave.

"I decided for the sake of my family and for my own sanity that I had to do something different. Eugene Nakfoor, MD, had been working full-time in the emergency unit at St. Lawrence Hospital then and was looking for help. The first thing Monday morning I called him and told him I was interested. I began closing up my private practice then and there.

"I had been on the job at St. Lawrence about two weeks when I realized that emergency medicine was a specialty unto itself. I began contacting some other physicians who were doing similar work. On August 16, 1968, eight of us met at the Holiday Inn in Lansing and formed the American College of Emergency Physicians. About half of us were from Michigan and kept in close contact in the early days."

One area of great concern to Doctor Wiegenstein was the status of emergency medical services.

"Physicians in private practice assumed that ambulance personnel were well trained, but those of us in emergency medicine knew it wasn't so. Our specialty concentrated attention on all phases of emergency care, including how the patient was managed before arrival at the hospital.

"There was little or no standardization of training and scant supervision of most ambulance services when ACEP started out. As a logical extension of our practice, emergency physicians became involved and helped set standards not only for initial training but also for continuing education for field personnel. It took a lot of commitment from our college members and from people like Dave Gilbert to help write paramedic exams."

Residencies

Doctor Wiegenstein, now chief of emergency medicine at Ingham Medical Center in Lansing, also helped found an emergency medicine residency program which is affiliated with Michigan State University.

"An important priority for our residents has been interaction with field personnel. I always considered it vital for physicians training in our specialty to understand fully just what is involved in field care. Talking to paramedics or to basic EMTs on the radio becomes a lot more meaningful after they've ridden the ambulance a few times. To utilize EMS efficiently, you must know what it's like to be in the front lines without all the hospital backup physicians are used to."

As more areas in Michigan and across the country upgraded their EMS Systems from the basic level, attention focused on medical control. In 1978 Mohammed Akhtar, MD, then chief of the EMS Division at MDPH, brought together physicians from around the state who were responsible for directing advanced life support programs.

At that time there was minimal contact among systems. These project medical director meetings facilitated idea exchanges, problem sharing, advice on EMS matters to MDPH and to the state legislature, establishment of minimal standards of care, and support for new programs.

Emergency Medical Services (EMS) Terminology

Basic life support (BLS) services are manned by emergency medical technicians (EMTs), who are trained in patient evaluation and stabilization, extrication, cardiopulmonary resuscitation (CPR), O_2 therapy, and military antishock trousers (MAST) application.

Intermediate EMTs receive additional training in IV fluid administration, endotracheal intubation, and esophageal obturator insertion.

Advanced life support (ALS) services are staffed by advanced EMTs (AEMTs, also known as Paramedics), who are trained in all the above plus drug therapy, dysrhythmia recognition and electrical conversion of dysrhythmias.

There are presently 70 ALS services in Michigan, with four applications on file. There are 47 intermediate services, with seven applications on file. The remainder of EMS in Michigan are BLS services, supplemented in some rural areas by First Responders who have skills similar to EMTs but fewer hours of classroom training.

The project medical director oversees all levels of EMS in a designated area and represents the system at the state level. The PMD also chairs an ALS advisory committee, comprised of representatives from hospitals and field providers participating in the system. Together they are responsible for developing written protocols for field care, auditing run reports, supervising local CME for EMS providers, and determining which drugs are carried by the paramedics.

EMS systems

Considering the enormous geographic and demographic diversity of Michigan, it is no surprise that each EMS system must develop individual means to serve its consumers. Most metropolitan areas are served by many hospitals (over 80 in Detroit, for instance), where any patient requiring immediate care can be transported to the nearest emergency department within a few minutes.

In these densely populated areas, a "load and go" approach is frequently preferable to commencing a full slate of advanced procedures at the scene. Basic life support with oxygen and MAST application suffices for most urban trauma victims under such circumstances. Even in a medical cardiac arrest where defibrillation fails it may be more efficient only to intubate the victim on scene and give medications intratracheally enroute, since a peripheral IV on an arrest patient is often time consuming in the field. Similarly, the number of drugs carried by urban ALS systems is usually small, and there will be little acute need to use medication drips.

Where distances are greater, most advanced systems are elaborate. At Marquette General, with a hospital-based advanced life support system, ambulance run times of 30 to 60 minutes are not uncommon and may be even longer in the winter. The victim of a high speed snowmobile accident on a remote logging road may not survive a lengthy trip to our facility, hence our paramedics are trained in such techniques as cricothyrotomy and needle decompression of the chest. Our drug box is large, and medication drips (e.g., dopamine for cardiogenic shock) are frequently necessary on longer runs.

The newest class of EMT, known variously as intermediate or limited advanced, is becoming increasingly popular in Michigan, particularly in rural regions where run volume is very low. Training expenses are less than for paramedic education because drug therapy is not included in the curriculum. Many areas use this class as a stepping stone to the advanced level.

The Michigan Chapter of the American College of Emergency Physicians has been a consistent supporter of emergency medical services in the state. The Chapter's EMS Committee is presently compiling protocols from advanced, intermediate, and basic services in Michigan to serve as a reference resource for those contemplating new or upgraded EMS systems. Medical control of BLS services, now mandatory only where higher levels of service exist, has been urged statewide by the Chapter. An EMS information library also is being developed. This year the Chapter helped sponsor its first Annual EMS Conference for field personnel, held in Mackinaw City. The EMS Committee continues to monitor and suggest actions by the State Legislature which affect pre-hospital care, such as mandatory seat belt use. The Chapter also has advocated using a portion of drivers' license fees to support EMS activities statewide. Alternative sources of funding for EMS are becoming necessary because most previously available Federal monies have been deleted from the budget. In addition, budgetary restrictions have resulted in drastically reduced staffing for the EMS Division of the Michigan Department of Public Health.

The future

What's on the horizon for EMS? One promising development now being investigated is computerized dysrhythmia recognition and defibrillation by a portable device suitable for use by Basic EMTs. Pilot studies in Seattle and in Iowa indicate improved survival rates for arrest victims when such devices are employed. Experimental programs are now under way in Detroit, Grand Rapids, and Cheboygan to assess the efficacy of this technique.

Comments Doctor Wiegenstein: "Emergency physicians should increase their efforts in promulgating citizen CPR. In Seattle, where over one-fourth of the adult population is certified in CPR, survival rates for arrest patients are impressive. I also think we can urge our colleagues in private practice to improve emergency care in the office setting. I know of large medical office buildings where cardiac patients are regularly seen which don't even have defibrillators."

Whatever methods are championed for improving pre-hospital care, one thing seems certain: the ultimate thrust of Emergency Medical Services must be the preservation of our most important organ — the brain. Cerebral resuscitation is one of the benchmarks by which our specialty is judged.

EMS in Michigan has a proud heritage. "Development of Emergency Services has progressed more rapidly in Michigan than in other states," observes Wayne McKenna, chief of the EMS Division at the Michigan Department of Public Health. "The first advanced life support systems to transport patients were in Michigan. The first rural ALS system was in Michigan. Emergency medicine was founded as a specialty in Michigan. Others can look to our state as an example of what can be accomplished when people are committed to quality EMS care."

OBESITY.

THE CONSEQUENCES CAN BE LIFE-SHORTENING.

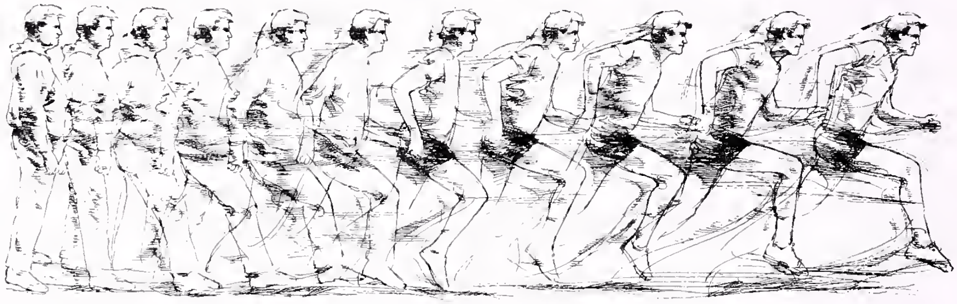
As physicians, every one of us knows the consequences of obesity: cardiovascular disease. . . diabetes. . . hypertension. . . congestive heart failure. . . an increased risk of sudden death.

Most of us also recognize how difficult it is for the obese patient to lose weight, not to mention the frustrations and failures that attend long-term maintenance of normal weight.

The Institute for Health Maintenance (IHM) can help.

Working in conjunction with a patient's primary care physician, IHM offers a medically sound regimen for therapeutic weight loss: THE RISK FACTOR OBESITY PROGRAM (RFO).

Developed under clinical conditions at major medical teaching institutions, the RFO Program combines a medically supervised supplemented fast with long-term behavioral and nutritional training.



Under the supervision of physicians and their staff, patients lose weight safely and consistently over a period of weeks and months, receiving their total daily nutritional requirements from a low-calorie egg albumen formulation supplemented with potassium and vitamins.

The success of the RFO Program has been significant.

Over the past five years, more than ten thousand patients have lost from 25 to over 400 pounds, with an average weight loss of 63 pounds. More important, 50% of patients admitted to our program have been able to sustain their new low weight levels for one year with the help of long-term maintenance.

Some patients have called the RFO Program "life-saving." As physicians, we know the relationship between certain risk factors and longevity. Obesity is one of those factors—one we can help reduce.

To learn more about us and how this program can safely benefit some of your patients, please contact University Health Center, 4201 St. Antoine, Detroit, Michigan 48201. (313) 832-2460.

The Risk Factor Obesity Program

Medically designed. Medically supervised. Medically sound.

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android® /5 mg. Buccal / 10 mg. Oral / 25 mg. Oral
Methyltestosterone U.S.P. Tablets

ANDROID® / F
Fluoxymesterone U.S.P. Tablets, 10 mg.

By Nancy Crandall

Auxiliary working to make membership infectious

The following article is taken from the installation address delivered by Mrs. Crandall as she took the MSMS Auxiliary's top office in May. A previous article in the July issue of *Michigan Medicine* also was taken from her installation address.

Our organization, since its founding in 1926, has been growing and developing, just as people do.

And just as people need to take stock, so our MSMS Auxiliary needs to see where it is headed, to see what it has accomplished, and to evaluate its growth.

Our growth is most easily measured in terms of membership. This is an area of concern, especially in this day of careers, working spouses, and the myriad of activities which demand our time and energies.

Growing to be done

The state medical society has a membership of over 10,000, but the auxiliary membership is just over 2,300. There is a lot of growing to be done here.

The membership committee has done a fine job this past year with its program of "let's make membership infectious." We need to spread the infectious spirit of Auxiliary around a little more.

The areas where our growth and development have enjoyed the most success are in health projects and health education. You have heard about education projects in which auxilians are involved in their own communities. There are statewide projects as well. Our involvement with the Organ Donor Awareness Program, the Child Passenger Safety Association, and the Michigan Health Council have helped our organization expand its efforts.

As the proportion of our older citizens increases and the problems of providing quality health care to them at a reasonable cost also increase, it is important for us to focus our attention on senior citizens. We already are involved in medicare information seminars, Meals on Wheels, and similar projects; but this is certainly an area of great potential for us.

Auxilians are involved in health education in the schools. But as "wellness" and "healthy lifestyle" programs become more widespread, we as physician spouses, parents, teachers and school board members will most certainly need to focus more attention in this area. Our Education Committee, chaired by Thild Bautista and Glenda Bunker, will assist county auxiliaries and help educate county officers and committees.

The Health Projects Committee, chaired by Dottie Csonka and Mary Lou Mathias, will assist county auxiliaries as they carry out health projects in their own communities. The AMA Auxiliary is continuing the national "Shape Up For Life" campaign begun in 1980. This is an umbrella program which promotes good nutrition, proper exercise, and stress management as a life-long program.

Another measure of the growth and development of an organization is in terms of dollars and cents. This past year we formed a special committee to examine the structure of MSMS-A. One of its recommendations was for the dues increase passed at the convention.

As a part of our examination of our organization, we must decide what we want to accomplish, when, and at what cost in terms of our yearly budget. This committee will function for the next two years and will make regular reports to the membership.

Dollars and cents

The other area of dollars and cents with which we are concerned is AMA-ERF. Michigan physicians and Auxilians have been generous supporters of the Education and Research Foundation. Through a variety of imaginative fund-raising projects, on county and state levels, they contribute to the total gift presented annually to approved medical schools. Clarice James again will be our resource for AMA-ERF fund-raising.

Legislation has become more important every year to those associated with medicine. The education of physician spouses about legislative issues has become imperative, but it is up to you to know the issues, to know how you can become involved, how you can clarify health issues for others and how you can work with your legislators to educate them about health issues. Again, this is another perfect area for auxiliary involvement and growth. Pat Allen and Audrey Tien will direct our legislative activity.

Mrs. Crandall of Muskegon is MSMS/A president.

EXCLUSIVE

MICHIGAN GAZETTE

TALWIN® Nx…BUILT-IN PROTECTION AGAINST MISUSE BY INJECTION

Major Analgesic Reformulated

Now contains naloxone, a potent narcotic antagonist

Extra security added to proven efficacy and safety

No longer do doctors have to deny patients the benefit of an effective oral analgesic for fear of its misuse by injection.

Winthrop-Breon Laboratories has met a nagging problem by reformulating TALWIN® 50 (pentazocine HCl tablets) with the addition of naloxone, equivalent to 0.5 mg base. The reformulated product is called TALWIN® Nx.

The original formulation had been subject to a form of misuse among street abusers known as "T's and Blues." TALWIN 50 and PBZ,* an antihistamine, would be ground up together, put into solution, and injected intravenously. The combination produced a heroin-like high. Because naloxone is a narcotic antagonist when injected intravenously, it acts to nullify any high a "T's and Blues" addict might expect from the pentazocine in a combination of TALWIN Nx and PBZ. When taken as directed orally, the naloxone component of TALWIN Nx is inactive. Thus, TALWIN Nx continues to be a safe, effective, oral analgesic for the relief of moderate to severe pain, now providing added security against misuse.

*Registered trademark of Ciba-Geigy Corp for tripelennamine.

T-540
NDC 0024-1951-04
100 tablets
CIV
Talwin® Nx
Each tablet contains pentazocine hydrochloride, USP, equivalent to 50 mg base and naloxone hydrochloride, USP, 0.5 mg.
Caution: Federal law prohibits dispensing without prescription.
Winthrop

Talwin® Nx

CIV Each tablet contains pentazocine HCl, USP, equivalent to 50 mg base and naloxone HCl, USP, equivalent to 0.5 mg base.

The reformulation of Talwin 50 to Talwin Nx involved the addition of 0.5 mg naloxone to help prevent misuse by injection.

Winthrop-Breon

© 1984 Winthrop-Breon Laboratories

Please see following page for Brief Summary.

Talwin® Nx ⓘⓥ

Each tablet contains pentazocine HCl, USP, equivalent to
50 mg base and naloxone HCl, USP, equivalent to 0.5 mg base

Analgesic for Oral Use Only

Contraindications: Hypersensitivity to either pentazocine or naloxone.

TALWIN® Nx is intended for oral use only Severe, potentially lethal, reactions may result from misuse of TALWIN® Nx by injection either alone or in combination with other substances. (See **Drug Abuse and Dependence** section.)

Warnings: *Drug Dependence.* Can cause physical and psychological dependence. (See **Drug Abuse and Dependence**) *Head Injury and Increased Intracranial Pressure* As with other potent analgesics, respiratory depressant effects of the drug may elevate cerebrospinal fluid pressure due to CO_2 retention; these effects may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Can obscure the clinical course of patients with head injuries, in such patients, use with extreme caution and only if deemed essential *Usage with Alcohol.* Due to potential for increased CNS depressant effects, alcohol should be used with caution *Patients Receiving Narcotics* Pentazocine is a mild narcotic antagonist Withdrawal symptoms have occurred in patients previously given narcotics, including methadone. *Certain Respiratory Conditions* Should be administered with caution in respiratory depression from any cause, severely limited respiratory reserve, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis

Precautions: *CNS Effect.* Use cautiously in patients prone to seizures, seizures have occurred though no cause and effect relationship has been established Therapeutic doses have in rare instances, resulted in hallucinations (usually visual), disorientation, and confusion, which cleared spontaneously within a period of hours. Such patients should be very closely observed and vital signs checked, if the drug is reinstituted, it should be done with caution since the acute CNS manifestations may recur *Impaired Renal or Hepatic Function.* Decreased metabolism of pentazocine in extensive liver disease may predispose to accentuation of side effects, it should be administered with caution in renal or hepatic impairment In long-term use, precautions should be taken to avoid increases in dose by the patient *Biliary Surgery* Some evidence suggests that unlike other narcotics pentazocine causes little or no elevation in biliary tract pressures, the clinical significance of these findings is not yet known. *Information for Patients* Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards. May cause physical and psychological dependence taken alone and may have additive CNS depressant properties in combination with alcohol or other CNS depressants. *Myocardial Infarction.* Use with caution in patients with myocardial infarction who have nausea or vomiting *Drug Interactions. Usage with Alcohol.* See **Warnings**. *Carcinogenesis, Mutagenesis, Impairment of Fertility* No long-term studies in animals to test for carcinogenesis have been performed *Pregnancy Category C* Should be given to pregnant women only if clearly needed. *Labor and Delivery* Use with caution in women delivering premature infants. Effect on mother and fetus, duration of labor or delivery, need for forceps delivery or other intervention or resuscitation of newborn, or later growth, development, and functional maturation of the child is unknown. *Nursing Mothers.* Caution should be exercised when administered to a nursing woman *Pediatric Use.* Safety and effectiveness in children below the age of 12 years have not been established

Adverse Reactions: *Cardiovascular:* Hypotension, tachycardia, syncope *Respiratory.* Rarely, respiratory depression *CNS Acute CNS Manifestations:* In rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours; may recur if drug is reinstituted *Other CNS Effects:* Dizziness, lightheadedness, sedation, euphoria, disturbed dreams, hallucinations, irritability, excitement, tinnitus, tremor. *Gastrointestinal:* Nausea, vomiting, constipation, diarrhea, anorexia, rarely abdominal distress *Allergic.* Edema of the face, dermatitis, including pruritus, flushed skin, including plethora. *Ophthalmic:* Visual blurring and focusing difficulty *Hematologic:* Depression of white blood cells (especially granulocytes), which is usually reversible, moderate transient eosinophilia *Other:* Headache, chills, insomnia, weakness, urinary retention

Drug Abuse and Dependence: *Controlled Substance* TALWIN Nx is a Schedule IV controlled substance

Dependence and withdrawal symptoms have been reported with orally administered pentazocine Patients with a history of drug dependence should be under close supervision Possible abstinence syndromes in newborns after prolonged use of pentazocine during pregnancy have been reported. In prescribing for chronic use, the physician should take precautions to avoid increases in dose by the patient. Tolerance to the analgesic effect is rarely reported, there is no long-term experience with oral use of TALWIN Nx

The amount of naloxone present (0.5 mg per tablet) has no action when taken orally and will not interfere with the pharmacologic action of pentazocine, however, this amount of naloxone given by injection has profound antagonistic action to narcotic analgesics TALWIN Nx has a lower potential for parenteral misuse than the previous oral pentazocine formulation, but is still subject to patient misuse and abuse by the oral route

Severe, even lethal, consequences may result from misuse of tablets by injection either alone or in combination with other substances, such as pulmonary emboli, vascular occlusion, ulceration and abscesses, and withdrawal symptoms in narcotic dependent individuals

Overdosage: *Treatment* Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated Assisted or controlled ventilation should also be considered For respiratory depression, parenteral naloxone is a specific and effective antagonist

Please consult full product information before prescribing

Winthrop-Breon
WIN 4-41415BR

Winthrop-Breon Laboratories
Division of Sterling Drug Inc.
New York, NY 10016

Vivian Lewis, MD: only a few women can't make an impact

By Willah Weddon

Third in a *Michigan Medicine* series on women physicians in medical leadership roles.

Practicing medicine as a female physician today is "a piece of cake," compared to how it was 20 years ago. So says Vivian Lewis, MD, Flint, as she recalls conditions when she began her internship at Hurley Hospital in 1963.

"The doctors' lounge then was where the men changed their clothes," she recalls with a smile. "So I had my coffee with the nurses."

Dressed in a tailored lavender suit, Doctor Lewis has been seeing patients all morning in the modern office building she and her surgeon husband, Billie Lewis, MD, own. They're located less than a block from Flint's St. Joseph Hospital.

A bulletin board on one wall in the pediatrician's large, predominately green and blue reception room is covered with snapshots of her patients.

"It began when one or two mothers brought in pictures of their children," she explains. Now the gallery has expanded to another wall.

First president

In 1978, Doctor Lewis was the first woman elected president of the Genesee County Medical Society (GCMS). When her term was completed she served as an alternate delegate to the MSMS House of Delegates. Last year she became a delegate.

A typical day for Doctor Lewis begins with a hospital committee meeting at 7:30 AM, and rounds at Hurley, St. Joseph or McClaren hospitals, where she has pediatric privileges.

She works in her office from 10 AM to noon and afternoons until 5 or 5:30. She sees about 25 to 30 patients daily, except Wednesday. This is a day "off," but actually begins after morning sessions spent in the hospitals.

Doctor Lewis' evenings often are filled with more meetings.

"I enjoy the interrelationships with people," she says, explaining she considers this her relaxing time in lieu of a hobby. She's involved with Teens of Alpha Kappa Alpha (TAKA), her college sorority project. The group awards scholarships to young students who have good grades, serve their community and are good salespeople.

Ms. Weddon is a Lansing-area freelance writer.

Doctor Lewis pays rapt attention at 1984 MSMS House of Delegates meeting.

Physician father

Doctor Lewis was raised in Oklahoma City where her father practiced medicine for 50 years.

The youngest of three children in the family, Vivian had an aptitude for music. She probably would have carried this into her college years if it hadn't been for her father's influence.

"I was filling out my college application and it asked what field I was entering," she recalls. "My father suggested I put down premed, so I did."

Her eldest brother is a dentist today in Oklahoma City. Her other brother was in medical school but had to drop out due to ill health. He later died, and it was Vivian who became the second generation physician in the family.

Graduation with an AB degree from Fisk University was followed by a marriage that "didn't work out." The young mother began graduate studies and worked in a research laboratory at the University of Oklahoma. It wasn't long before her medical background led her to apply for admission to the school of medicine.

Two years later Vivian and Billie Lewis, a classmate, were married; both graduated in 1959. The couple moved to Flint where she began her internship and residency at Hurley Hospital. Within these three years their two children were born.

Although she'd wanted to specialize in OB-GYN, Doctor Lewis found this field closed to women. She opted for pediatrics. "You adapt," she muses. "If you want to get to point B from A, you can shift your route but still reach your destination."

Doctor Lewis began practicing in the Mott Children's Health Center in Flint and was there until six years ago when she entered private practice in the couples' office building.

"Our professional lives mesh well," Doctor Lewis says. "My husband is involved in other things, too, and it allows a certain degree of independence for both of us. We can truly appreciate the time we spend together."

Today their eldest daughter, Vivian Sanford, is a resident physician at Louis Weiss Hospital in Chicago; son William is serving in the U.S. Army and daughter Beverly is a college student at the University of Michigan-Flint.

Her profession

Through the years of raising a family, studying, practicing medicine and taking an active role in her community, Doctor Lewis has carried a heavy schedule. But she manages her personal and professional life, she says, "By going all the time."

"A woman clearly has more demands on her," she admits. "My husband has always been supportive, but women are always going to be primary caretakers of the children."

Would she encourage young women to enter the medical profession today?

"I guess I still would, though I've had some questions about the medical profession itself," she replies candidly. "My concerns have been the political environment we find ourselves in now . . . and how malpractice is interpreted. But, I think we'll work these out eventually."

"People always will need physicians and there's a satisfaction in practicing medicine," she continues. "There's the work with people and the gratification of doing something worthwhile."

Doctor Lewis sees the state medical society's future in overseeing quality of patient care, "as there's no one else to do it."

As for women physicians taking part in MSMS, she feels there are opportunities for them. She would like to see more of them become active.

"It would be helpful to have all its components represented in organized medicine," she says.

"I've been going to meetings since the 1970s. At the last meeting this spring, there were more women participating in leadership roles than I've ever seen."

"But only a few women can't make an impact," she warns.

Here's what's in store for you at 1984 Annual Scientific Meeting

Are you a physician in your 30s or 40s? Are you a surgeon? Are you in clinical medical practice? Would you like to formally present your scientific experiences to your colleagues through a poster exhibit?

If so, the MSMS Annual Scientific Meeting Planning Committee extends a special invitation to you to attend their annual three-day session of Category I CME courses Nov. 13-15 at the Hyatt Regency Dearborn.

According to David Rovner, MD, East Lansing, chairman of the meeting, the committee is planning to make the meeting especially welcoming to younger physicians and to surgeons.

This is in addition to the wealth of offerings they provide for physicians of all ages and specialties.

Younger MDs

Younger physicians haven't been as well represented in past meetings as the committee would like. That is one of the reasons for the poster presentations, a new feature this year for the Annual Scientific Meeting, and one which may be especially amenable to newer physicians.

The opposite condition is true in regards to surgeons. Doctor Rovner and his committee have noted an especially good representation of surgeons among the physicians attending the Annual Scientific Meeting in past years. They, therefore, are planning a good number of courses this year for surgeons' benefit.

Let's take a run through the courses planned, by areas of study, for a good look at what's available.

Surgery: There are courses on breast reconstruction, alternative forms of therapy for primary breast cancer, low back pain therapy, colonoscopy, spinal cord injury, and the pathophysiological basis of acute care reconstruction and research of trauma.

Ob/Gyn: Conservative management of early breast cancer is one of the offerings in this area, which also includes courses on coping with tragic events in obstetrics and gynecology, carcinoma of the female reproductive tract, and what's new in prenatal care, labor and delivery.

Neurology: Neurological experts are presenting courses on brain ischemia, strokes, neurological problems of general interest and frequent encounter, evaluation and treatment of the dizzy patient, epilepsy in children, current management strategies for headache disorders, and Alzheimers Disease.

Emotional/Behavioral: New developments in treating depression will be described as well as psychiatric aspects of medical practice; attachment disorders in infancy; clinical developments in anxiety states and panic disorders which experts will reveal are a more common than thought medical problem.

Radiology: In this field, there are courses planned on conservative management of early breast cancer, the modern approach to clinical diagnostic radiology, and chest roentgenography for the clinician.

Pediatrics: Pediatricians may attend a course on the state of the art of follow-up on high risk infants, or another on common laryngeal diseases in children and adults, also the one about epilepsy in children and another on behavioral pediatrics.

Internal Medicine: For internists, the ASM committee is planning courses on brain ischemia; use, abuse and interpretation of renal assessment tests; hematology, the non-invasive vascular lab (this one will have a focus on what the primary care physician needs to know), arm pain and dysfunction, hypertension, diabetes, diarrhea, cholesterol and coronary artery disease.

Other offerings

Ophthalmology: Ophthalmologists, and other physicians wishing to know more about the discipline, may attend courses on saving sight, and on studies, standards and solutions in ophthalmology.

Cardiac Life Support: Physicians may earn certification in BCLS by attending courses provided every morning during the three-day session, and may recertify their skills in advanced cardiac life support.

In addition, *dermatologists* will present courses for the specialist and the generalist; *emergency physicians* will offer a course on management of office emergencies, and there will be additional courses on occupational health concerns, elder care management, local anesthetics, drug level monitoring, clinical nutrition, allergy, nonoperative office and sports problems of the arm, nuclear medicine, headache disorders, low back pain, rheumatology, male infertility and impotence, peripheral nerve disorders, sports injuries, and medical ethics and malpractice.

For greater details, watch for the September issue of *Michigan Medicine* and for coming issues of the *Medigram* newsletter. Or you may contact Sherry Fent at MSMS headquarters, 517/337-1351.

Osteoporosis

By Joan C. Stryker, MD, FACOG

With this issue of *Michigan Medicine,* the MSMS CME Programming Committee continues its new feature. This special section contains an educational article of general interest to physicians, followed by a quiz which can be filled out and returned to MSMS headquarters. The deadline is December 1. Physicians who correctly answer at least 80 percent of the questions will earn one hour of Category I CME credit, for the minimum charge of $3 for MSMS costs. The quiz will be evaluated and returned to you with appropriate comments. In addition, there is space allowed for you to comment and to ask further questions.

Osteoporosis is a major underlying cause of bone fractures in all older persons, but has an increased prevalence in postmenopausal women. The National Institute of Health (NIH) recently reported that osteoporosis is a common condition, affecting as many as 20 million individuals in the United States. Approximately 1.3 million fractures attributable to osteoporosis occur annually in people aged 45 years and older, at an estimated cost of 3.8 billion dollars. Statistically, of those who live to the age of 90, 32 percent of the women and 17 percent of the men will suffer a hip fracture.

Bone is composed of a collagen-rich organic matrix impregnated with minerals, primarily calcium and phosphates. Bone undergoes continuous remodeling or turnover throughout life. Osteoclasts reabsorb bone, forming a microscopic cavity: osteoblasts then reform the bone surfaces filling the cavities. This process is continuous, and bone reabsorption and formulation are linked closely in space, time and degree. Peak bone mass is achieved at about 35 years of age for cortical bone and earlier for trabecular bone. Mechanical and electrical forces, hormones and local regulatory factors influence the remodeling. With advancing age and the decrease in bone skeletal mass, resulting in atrophy (to be porous), there is an increase in fractures of the spine, wrist and hip.

Vertebral bodies contain predominantly trabecular bone, while the proximal femur contains predominantly cortical bone. There is a difference in the responses of the two forms of bone, both to metabolic influences and susceptibility to fractures, because osteoporosis does not affect all the cortical or trabecular bones in the same degree at the same time.

The loss of trabecular bone is accelerated in women aged 35 to 75, with compression fractures usually affecting vertebrae thoracic 8 to lumbar 3. Compression fractures may occur during routine activities, such as bending, lifting, or rising from a chair or bed. Clinically, there is an immediate severe local back pain. The pain usually subsides in several months, but in some individuals, pain may persist for years. A gradual asymptomatic vertebral compression may also occur, which can be detected only on a radiographic examination, or may be recognized by loss of body height or the development of kyphosis. Multiple vertebral compression fractures shorten the spine and can lead to chronic alveolar hypoventilation, retention of bronchial secretions, and repeated episodes of pneumonia. Abdominal symptoms may include early satiety, bloating and constipation. Damage to the spinal cord and peripheral nerves is infrequent.

Cortical fractures of the femur, tibia, fibula or hip are other manifestations of osteoporosis, most frequently occurring in the older white woman of small stature. The acute complications are hospitalization, depression, and/or a mechanical failure of the surgical procedure. Most patients fail to

---

Doctor Stryker is professor, Department of Obstetrics and Gynecology, Wayne State University School of Medicine, and is affiliated with Hutzel Hospital, Detroit.

recover normal pre-fracture activities and 20 percent will die within one year.

Who is at risk for developing osteoporosis?

White, nulliparous, underweight, postmenopausal women are at the highest risk for developing osteoporosis. Smoking may be an additional predictor of risk. Calcium deficiency has also been implicated. Immobilization and prolonged bed rest produce rapid bone loss in all persons, and sedentary habits accelerate the process. The relationship of osteoporosis to dietary factors, such as alcohol, vitamins A, C and D, and magnesium and proteins is less firmly established.

Etiology of osteoporosis

Albright, by his astute observations and articles, first made us aware that there is a definite relationship between estrogen deprivation and osteoporosis. Among the many possible etiologies of primary osteoporosis, the current data point to two probable causes: deficiency of estrogen and deficiency of calcium. Rapid bone reabsorption often accompanies menopause, and premature osteoporosis follows bilateral oophorectomy when performed in younger woman. Estrogen replacement prevents bone loss in both conditions. Calcium deficiency in experimental animals causes osteoporosis, while calcium supplementation reduces bone loss. Ironically, calcium deficiency is common among the elderly in the United States. A decrease in calcitonin secretion is accelerated by loss of estrogen during menopause and this makes the skeleton more sensitive to the actions of the bone-resorbing hormones.

As has also been noted in the literature, there is a difference in the incidence of osteoporosis between ethnic groups, with an increased rate of fractures noted among whites. A non-white person, regardless of where he lives, *i.e.,* Scandinavia, South Africa, New Zealand, or Minneapolis has a decreased incidence of osteoporosis and fractures.

Identifying the at-risk patient

There is no blood or urine test specifically designed to diagnose primary osteoporosis. Several non-invasive methods are available to evaluate bone density, but these vary widely in cost, availability and radiation dose. Standard radiographs of the spine are most widely used; however, radiographs are insensitive indicators of bone loss, since bone density must be decreased by at least 20 to 30 percent before the reduction can be appreciated. Other tests include radiogrammetry for measurement of cortical thickness, the Singh Index of femoral trabecular patterns, and computed tomography. The latter is the most accurate method for determining BMD. Doctor Morris Notelovitz of Gainesville, Florida, has shown conclusively the relationship of exogenous estrogens and dietary calcium intake to BMD* by utilizing the single and dual photon absorptiometry at his Clinic for Climacteric Study.

Doctor John Studd of King's Cottage Hospital, London, England,** is now utilizing skin biopsy for collagen density and correlating the results with radiographic studies. He has shown a definite correlation between the amount of collagen in the skin and the degree of osteoporosis. A decrease in skin collagen is directly related to an increase in osteoporosis and the incidence of fractures.

Invasive methods, such as biopsy of the iliac crest, will give a more accurate index of bone density for trabecular bone.

Can osteoporosis be prevented and treated?

Physicians must emphasize measures that retard or halt the process of osteoporosis before irreversible structural defects occur. The mainstays of prevention and management of osteoporosis are estrogen and calcium, while exercise and nutrition may be important adjuncts.

Estrogen replacement therapy is the most effective single treatment modality for the prevention of osteoporosis in women. Even when started as late as six years after the menopause, estrogen can prevent further loss of bone mass. It does not, however, restore it to a premenopausal level.

Estrogen is most frequently prescribed cyclically by mouth and protects at low doses, such as 0.625 mgs of conjugated equine estrogen, 25 micrograms of mestranol, or 25 µg of ethinyl estradiol daily. Estrogens also are absorbed systemically by the cutaneous route and thus bypass the liver. The transdermal application of estrogen can be as an ointment applied to the abdomen or can be instilled as a cream intravaginally. In England, subcutaneous implanation of estrogen pellets is efficacious.

If a woman has had an oophorectomy before the age of 50, cyclic estrogen therapy should be started postoperatively. Following a natural menopause, a woman should be considered for cyclic estrogen therapy within six months. For the non-hysterectomized patient, the addition of a progesterone in a sequential cyclic regimen probably reduces the risk of endometrial cancer. The continuation of estrogen therapy should be for at least 15 years. It is needless to add that any person on a prescribed medication will require close monitoring, and that estrogen should not be prescribed if there is a specific contraindication to its use.

The usual daily calcium intake per person in the United States is 450 to 550 mgs, which is well below the National Research Council's recommended dietary allowance of 800 mgs. Calcium metabolic balance studies indicate a daily requirement of about 1,000 mgs of calcium for premenopausal and estrogen treated women. Postmenopausal women, who are not treated with estrogen, require 1,500 mgs daily for calcium balance. In most studies, high dietary calcium suppresses age related bone loss and reduces the fracture rate in patients with osteoporosis. It therefore seems likely that an increase in calcium intake to 1,000 to 1,500 mgs a day would reduce the incidence of osteoporosis in postmenopausal women. Normal levels of Vitamin D are required for optimal calcium absorption: there is also an increased requirement for Vitamin D with age.

It is known that inactivity leads to bone loss. Recent studies suggest that moderate weight-bearing exercises, such as briskly walking a mile every day, may reduce bone loss and are highly recommended. Strategies to prevent falls also are important, especially for the elderly patient population.

Summary

In summary, the person at most risk for developing osteoporosis and subsequent fractures is the thin, white woman with estrogen deprivation. Perimenopausal and postmenopausal white women should be offered exogenous estrogen therapy. The addition of a progesterone in a sequential cyclic regimen should be included if they have retained their uterus. Over 35 years of age, an increase in calcium intake and exercise will help modify the development of osteoporosis.

Continued on page 405

---

* *Bone mineral density*

** *Direct contact and observation at his clinic in London, England.*

The AMA
puts current information at your fingertips.

The first nationwide medical information network brings a new dimension to the way in which physicians and other health care professionals keep abreast of the latest knowledge in their profession.

Now, through the use of a low-cost computer terminal or personal computer, you can have instant access to authoritative and up-to-date information. The American Medical Association's computerized data bases place a wide range of professional resources at your fingertips, such as clinical, administrative, medical practice information, and abstracts of current clinical literature. Physicians can earn Category I, Continuing Medical Education (CME) credit using the Massachusetts General Hospital Continuing Medical Education programs or can elect to use the MGH-CME programs as informational updates or refresher courses.

Adding a new dimension to the way in which you communicate is MED/MAIL electronic mail. With the same terminal, you can send messages to your colleagues across the country or across the city . . . in minutes.

Information that could take hours to acquire through traditional channels can now be gathered in minutes, giving you valuable extra time for other important activities. And you can use the medical information network at your convenience, 24 hours a day, from your office, hospital or home.

It's surprisingly economical and professionally indispensable.

GTE Telenet

Medical Information Network

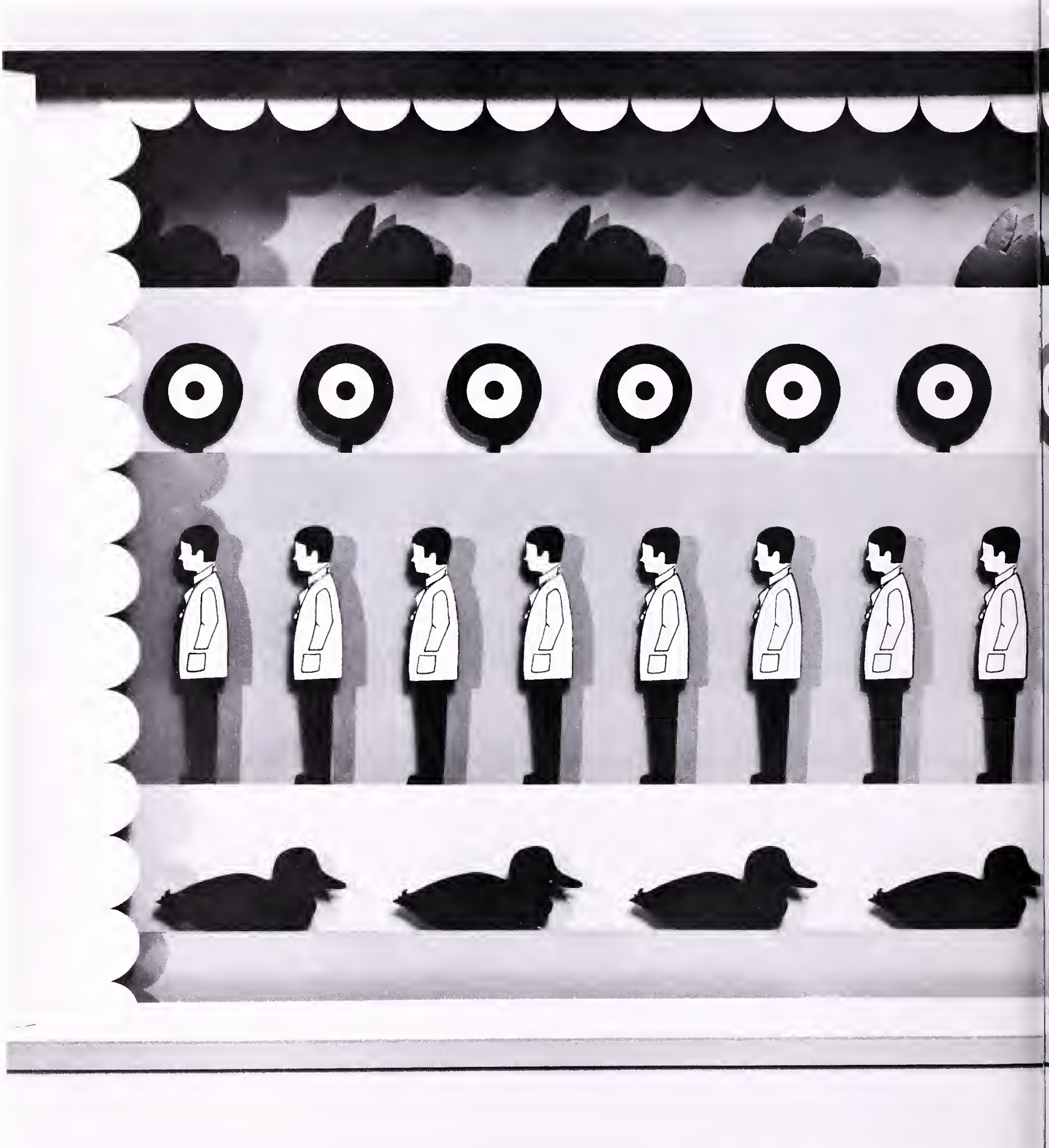
FOR SUBSCRIPTION INFORMATION PLEASE CONTACT

PHYSICIAN SERVICE GROUP, INC.
A member service subsidiary of the
MICHIGAN STATE MEDICAL SOCIETY
EAST LANSING, MICHIGAN

Ellen Vinocur Potash
Telephone 517/337-1351

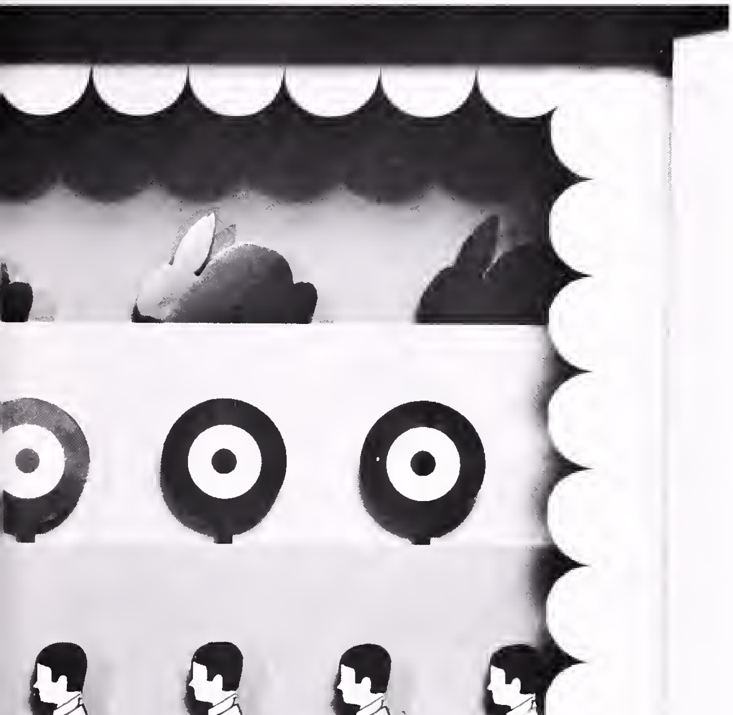
GTE

If you become the target of a



©1983 MPMLC

professional liability claim...



You will be glad you have Michigan Physicians.

Michigan Physicians has been solving complex medical professional liability problems since 1976. With the state's largest and most experienced claims staff, Michigan Physicians works with you to resolve claims (and incidents) that most physicians have never faced in their careers.

In a changing legal environment, you need the best coverage you can buy because the risk of a professional liability claim is becoming greater every day.

For a confidential rate quotation and more information about Michigan's leading physician-owned insurance company, call or write the office in your area.

Michigan Physicians
Mutual Liability Company

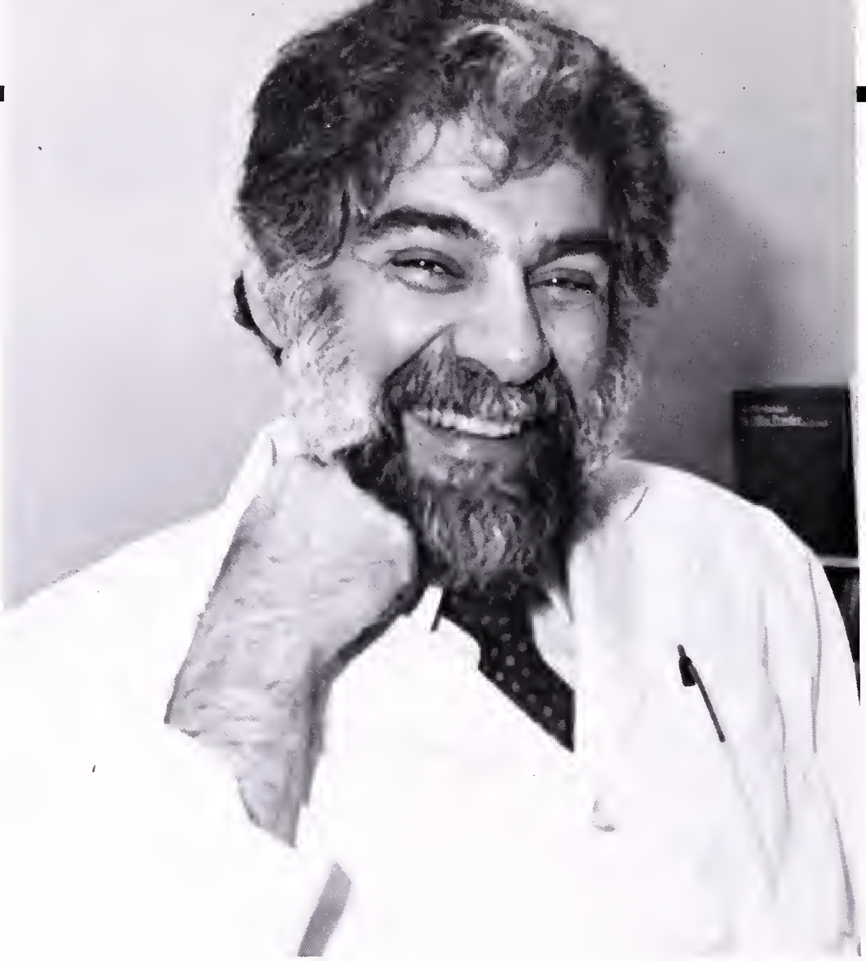
1305 Abbott Road
East Lansing, MI 48823
(517) 351-1150
(800) 292-1926

6735 Telegraph Road
Suite 205
Birmingham, MI 48010
(313) 647-5550

Endorsed by the Michigan State Medical Society

Meet the new MSMS president: Louis R. Zako, MD

By Carole Eberly



Doctor Zako in a relaxed moment in his office.

It's the little things that give Doctor Louis Zako away.

It's the oil painting on the wall created for him by a patient whose eight-year-old boy died of a brain tumor.

It's the 25-volume collection of current magazines — from *Car and Driver* to *Better Homes & Gardens, U.S. News and World Report* to *Glamour* — neatly displayed for waiting patients in large, attractive wooden racks.

It's his eagerness to sit beside visitors in a maple armchair rather than talk from behind his paper-, pamphlet- and book-covered desk in his Dearborn Heights office.

Doctor Zako not only cares for people, he also cares *about* them. And there is a big difference.

"Physicians must be clinically competent, have a strong code of ethics, and feel empathy/compassion for their patients," he says. "Some say you can't teach compassion, but that's not totally true; we're all great imitators."

He says compassion, which is taught in the family, can be lost in the "test of fire" of medical school, internship and residency.

Doctor Zako says if a student lacks role models who consider empathy an important part of medicine, they may decide "it's not a part of being a good doctor; it's just not important."

"I think medical schools have an obligation to produce physicians skilled in both the art and science of medicine," he emphasizes.

When Doctor Zako graduated from the University of Michigan School of Medicine in 1957, he knew everything there was to know at that time about lupus erythematosis.

"But I didn't know how to cope with patients who were depressed or suicidal or patients who were alcoholics," he says. "In 22 years, I've had one patient with lupus and hundreds of patients with alcoholism. Where are the priorities?"

Doctor Zhivago

Doctor Zako's calm, relaxed manner contrasts with the intensity of his firmly held principles of compassion. With salt and pepper hair and beard to match, he is Central Casting's idea of Doctor Zhivago. Warm, friendly, loquacious and witty, he talks at length and with ease about everything from the need for compassion in medicine to physical fitness.

A man seldom at a loss for words, he warms up to his primary message as spokesman of the Michigan State Medical Society. He leans forward in his chair, making sure his words are not lost.

"I'm not naive and innocent," he starts out. "I'm well aware this is a very difficult and complex world. I realize the medical soci-

---

Ms. Eberly is a Lansing-area freelance writer.

ety needs to be effective in political, legislative and socioeconomic arenas. The members demand this, and I think we are doing an excellent job in those areas.

"But if the medical profession in the United States is to retain a reasonable degree of professional freedom," he emphasizes, "we're going to have to make a recommitment to our patients."

Doctor Zako says if physicians are honest with their patients, care about them and provide excellent care day in and day out, they still will get sued and congressmen still will try to mandate Medicare assignments.

"But we will win most of the battles," he says. "So being a good person and a good doctor is the best single way to preserve what we have."

Practice changes

Doctor Zako's medical practice has changed dramatically since 1961, when he began a traditional solo arrangement.

In the mid-1960s, he began wondering about the viability of his field of medicine. He considered leaving family medicine for a specialty.

Then family practice began to develop as a specialty and the American Board of Family Practice was created. There was increased awareness of and value placed on family practice in universities and colleges.

In the early 1970s, Doctor Zako began teaching on a limited basis at Wayne State University School of Medicine. There he came in contact with faculty members from the schools of social work and nursing. Soon Doctor Zako began accepting graduate students in social work in his practice for field study. In addition, he was training future nurse clinicians in family practice.

Coincidentally, Doctor Zako's wife, Mary, enrolled in the nurse clinician program at Wayne State. She now works with him three days a week, and he also has a social worker on his staff.

His wife has charge of such duties as health education, monitoring chronically ill patients and certain pre-natal care activities. The social worker may see patients who are facing serious physical illness or who have marriage problems, adolescent behavior disorders or depression problems.

At first, he says, there was a fair amount of resistance to the changes made in his practice. "But after a year or two, the vast majority of our patients found this a very acceptable variation. I don't think we lost but three or four families when my practice changed."

Doctor Zako says there are nothing but advantages in working with Mary.

"We get along very, very well. And we have other interests. We don't carry the practice home, so it's not our whole life. Actually, working together has enhanced our personal relationship."

Besides working together, Doctor Zako and his wife like to run together.

"Jogging is a very important part of our lives," he says. "We run an average of three miles in the morning both at home and when we're traveling. It gives me endurance throughout the day and I just feel better."

The Zakos have one child, a son, Robert, 24. A recent mathematics graduate of Harvard College, Robert shortly will begin work on a PhD in physics at the University of California in Berkley.

Family man

For Doctor Zako, who was considering leaving family practice when it was "near death" just a few years ago, the comeback of this branch of medicine is especially satisfying.

"I'm a family-type person," he says. "I believe in families and their strength. Family medicine permits me to practice what I believe."

He blames much of the disinterest in family medicine on post-World War II's fascination with technology.

"But technology will never bring human contentment," he suggests. "It's simply a tool, not a god. You can blow people off the face of the earth with it or you can make arid deserts bloom. I think we were too imbued with the wonders of technology.

"I think the pendulum is now swinging back toward a more wholesome middle ground. We're beginning to talk about issues like the bioethics of the terminally ill, informed consent, organ transplants and the rationing of health care."

Society the answer

What does Doctor Zako see as the answer to rising health care costs?

"There is no easy answer," he replies. "What do you do when the population is aging?

"All you have to do is compare how often kids get sick and hospitalized with their grandparents' experiences to realize our health care costs are going to go through the ceiling. There's no way we can avoid it."

Doctor Zako also believes that effective health education programs could go a long way in helping reduce health care costs. He cites anti-smoking campaigns as one example.

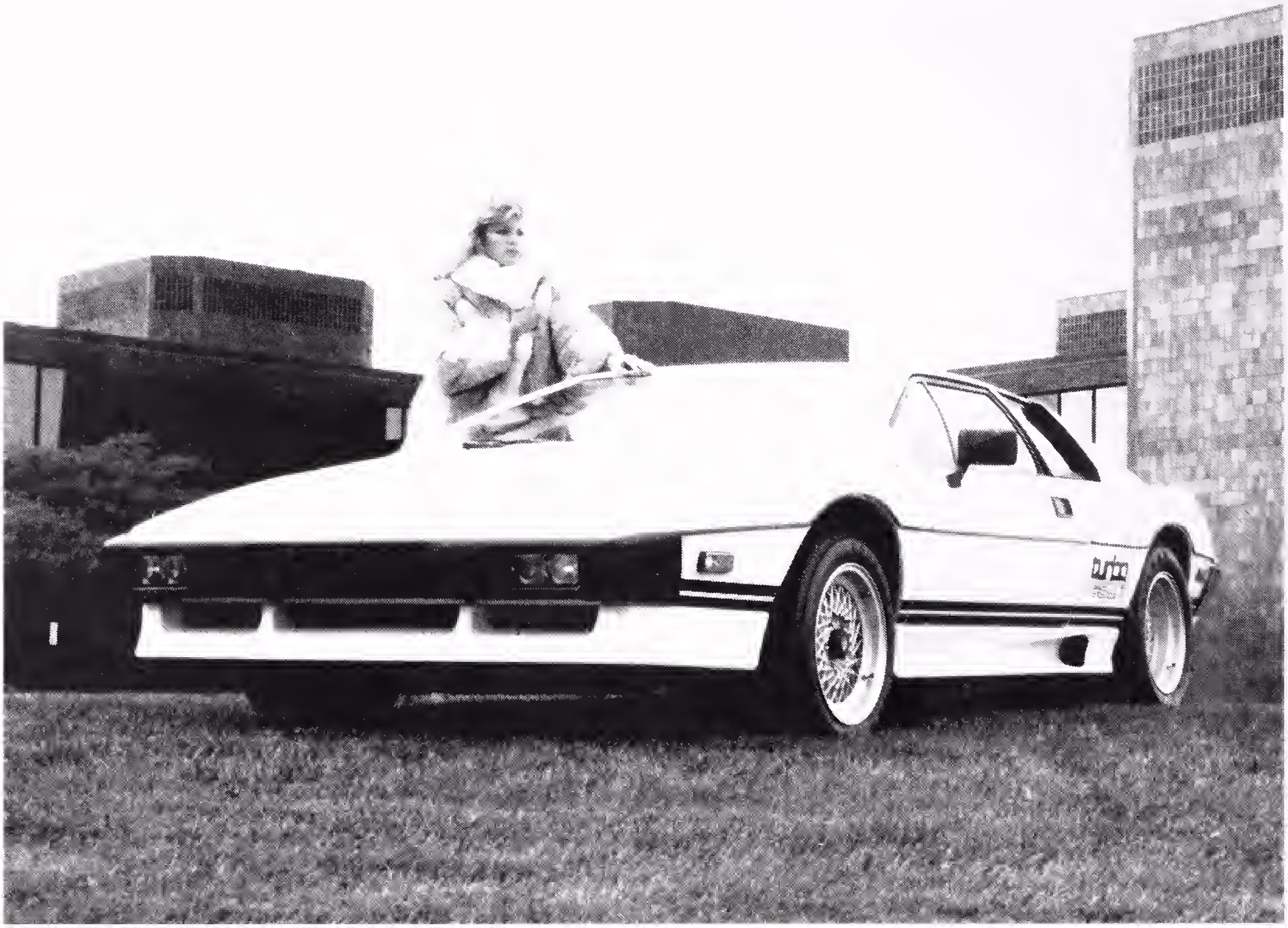
He believes much of the solution to high costs is largely out of reach for medical professionals.

"The solution lies with society at large," he says. "And I believe the medical profession has not done enough to involve society.

"In the long run, society suffers in several ways," he says. "The quality of care deteriorates because the physician and the patient are potential adversaries rather than people working together for a mutual goal — restoration of good health."

How does Doctor Zako survive a grueling agenda which finds him involved in Michigan State Medical Society politics, also everything from co-chairing Michigan Physicians for Reagan-Bush to belonging to the Motor City Striders jogging group?

"With a lot of difficulty, but with a great deal of enthusiasm," he says.



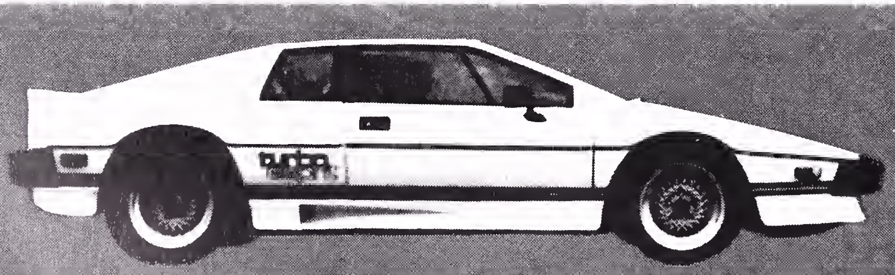
Announce your arrival.

When you arrive in the Lotus Turbo Esprit, you're completing a trek that began almost three decades ago and has covered the road and race courses of four continents.
This 16-valve mid-engine masterpiece of the automaker's art delivers all the muscle, finesse and sophistication that any serious driver, road or track, could ask of the name Lotus.
Wherever you're going, when you get there, be sure you arrive in a Lotus Turbo Esprit.

For further information on the Lotus Turbo Esprit,
write: LOTUS
Birmingham Motors, Ltd.
479 S. Woodward Avenue
Birmingham, Michigan 48011

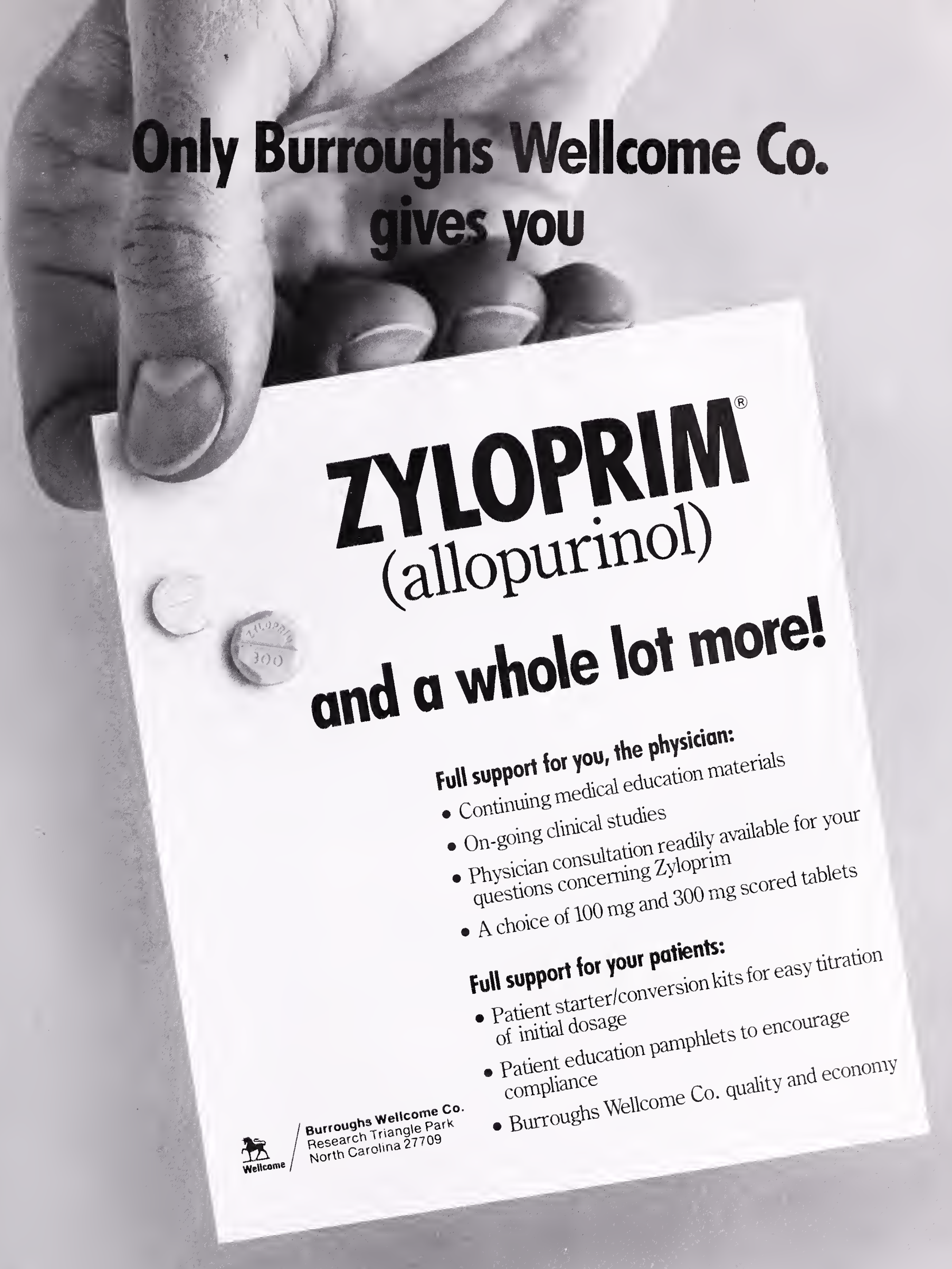
Gentlemen:
I find the Lotus Turbo Esprit a most intriguing automobile. Please send me full particulars on this remarkable sports car.

Name ________________
Address ________________
City/State/Zip ________________
Telephone ________________



LOTUS

BIRMINGHAM MOTORS, LTD.
479 S. Woodward, Birmingham MI 48011 (313) 646-3980



Only Burroughs Wellcome Co. gives you

ZYLOPRIM®
(allopurinol)

and a whole lot more!

Full support for you, the physician:

- Continuing medical education materials
- On-going clinical studies
- Physician consultation readily available for your questions concerning Zyloprim
- A choice of 100 mg and 300 mg scored tablets

Full support for your patients:

- Patient starter/conversion kits for easy titration of initial dosage
- Patient education pamphlets to encourage compliance
- Burroughs Wellcome Co. quality and economy

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Competence counts

Hurley Medical Center photo

In selecting a doctor, 74 percent of Americans consider competence, not cost.

Competent doctors remain the key to health. But competence isn't immunity to litigation.

Consider our competence – and our professional liability protection and strong-defense philosophy.

We defend you against non-meritorious claims. We won't settle a claim without your approval or merely to cut our defense cost.

PICOM
Physicians Insurance Company Of Michigan
4277 Okemos Rd., Box 1000
Okemos, Michigan 48864
(517) 349-6500
(313) 557-4845
1-800-292-1036

Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

* **WARNING**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

In Hypertension*… When You Need to Conserve K^+

Remember the Unique Red and White Capsule: Your Assurance of SK&F Quality

*Serum K^+ and BUN should be checked periodically (see Warnings and Precautions).

Potassium-Sparing

DYAZIDE®

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

Over 17 Years of Confidence

The unique
red and white
Dyazide® capsule:
Your assurance of
SK&F quality.

DYAZIDE
SKF

a product of
SK&F CO.
Carolina, P.R. 00630

©SK&F Co., 1983

Motrin®
ibuprofen, Upjohn
600 mg Tablets

MOTRIN 600mg
MOTRIN 600mg
MOTRIN 600mg
MOTRIN 600mg

More convenient for your patients.

Upjohn

© 1984 The Upjohn Company

The Upjohn Company • Kalamazoo, Michigan 49001 USA

J-4044 January 1984

continued from page 394

CME Quiz

The MSMS Committee on CME Programming, an organization accredited by the MSMS Committee on CME Accreditation, certifies that this activity meets the criteria for a maximum of one credit hour in Category I toward the requirements for Michigan relicensure and of the Physician Recognition Award of the AMA provided it is completed as designed.

To obtain one hour of Category I continuing medical education credit, please answer the following questions by circling the correct answer below. Complete and clip this entire page and mail it by Dec. 1 to: Sherry L. Fent, Chief, Section on Physician Education, MSMS, 120 W. Saginaw Street, East Lansing, 48823. Be sure to include a $3 administrative charge.

Circle or check the correct answer.

1. What is the estimated number of persons, in millions, affected by osteoporosis in the US today?

5 ____ 20 ____ 30 ____
10 ____ 25 ____ 40 ____
15 ____

2. What percent of all men will suffer a hip fracture by age 90?

15 ____ 19 ____ 29 ____
17 ____ 23 ____ 35 ____

3. What percent of all women will suffer a hip fracture by age 90?

18 ____ 26 ____ 32 ____
20 ____ 30 ____ 42 ____

4. In the US, what is the estimated cost of required health care due to osteoporosis (in billions)?

1.0 ____ 3.8 ____
2.5 ____ 5.5 ____

5. Osteoporosis is due to:

Increase in bone reabsorption? ____
Decrease in bone formation? ____
Both of the above ____

6. The following variables increase the degree of severity of osteoporosis:

Inactivity ____
White women ____
Weight-bearing exercises ____
Black women ____
Decrease in endogenous estrogen ____
Increase in FSH ____
Decrease in daily calcium intake ____
Increase in daily carbohydrate intake ____

7. Today, what is the most accurate, noninvasive method to determine degree of bone mass density (BMD)?

Radioscopy ____
Single or dual photon absorptiometry ____
Singh index ____

8. What is the most accurate invasive method to determine bone mass density?

Iliac crest biopsy ____
Blood calcium levels ____
CAT scan of vertebrae and cortical bones ____
Bone marrow biopsy ____
Skin collagen density ____

9. What are the three major components for the prevention of osteoporosis?

prednisone ____
exercise ____
estrogens ____
iron ____
calcium ____
potassium ____
thyroid extract ____
Vitamins A & D ____
Vitamin C ____

10. Can a patient with severe osteoporosis be cured?

Yes No Maybe

11. Can there be remission of symptoms?

Yes No

12. What are the risks to a patient on sequential cyclic hormonal therapy?

(Circle all correct answers)

thromboembolic phenomenon
increase in LDHP
hypertension
endometrial carcinoma
breast carcinoma

13. What are the benefits of sequential cyclic hormonal therapy?

(Circle all correct answers)

alleviation of vasomotor symptoms
prevention of osteoporosis — therefore a decrease in fractures
increase in a feeling of well-being
increased mental capacity
increase in physical strength
increase in vaginal lubrication

14. Does exogenous sequential cyclic hormones in the postmenopausal woman increase the risk of cancer developing in the breast, cervix, colon, liver, endometrium, ovary?

Yes No

15. In the postmenopausal woman, what two hormones show the greatest change in values?

testosterone ____
prolactin ____
estradiol ____
LH ____
FSH ____
pregnandiol ____
T3 ____

16. What are the salient features of osteoporosis in an x-ray?

(Indicate the positive findings)

biocavity of the vertebrae ____
translucency ____
low Singh index of femur ____
irregular deformation ____
decrease in the degree of condensation of cortical bone (calcar thickness) ____
all of the above ____

17. What is sequential cyclic hormonal therapy?

testosterone ____
estrogen and testosterone ____
cortisone ____
estrogen and progesterone (cyclic) ____
thyroid ____

18. The dosage should be

2.5 ____
1.25 ____
0.625 ____
0.3 mgs ____

of conjugated estrogens for 21 days.

19. The dosage of progesterone should be

30 ____
20 ____
10 mgs ____

the last 10 days of a 28 day cycle.

20. What length of time is considered adequate for treatment to prevent osteoporosis?

6 months ____
2 years ____
5 years ____
10 years ____
forever ____
unknown ____

Please continue on back side

I wish to apply for one hour of Category I CME through the MSMS Committee on CME Programming. I have read the article and completed the quiz. I understand that my answer sheet will be graded confidentially, and that notification of my successful completion of the quiz (80 percent of the questions answered correctly) will be sent to me. I also understand that if I do not answer 80 percent of the questions correctly, I will not be eligible for the one-hour Category I credit but may record and/or report the activity in Category V.

____
Name (please print or type)

____
Address

____
City, State, zip code

____
ME number (above name on *Michigan Medicine* mailing label)

____
Signature

Evaluation/Comments: ______________________________

____

____

____

____

____

By Joyce Crum

George W. Morley, MD, Ann Arbor, is the new vice president of the 24,000 member American College of Obstetricians and Gynecologists. Doctor Morley was recognized by Town and Country Magazine in 1978 as one of the top 10 gynecologic oncologists in the United States and was awarded ACOG's Outstanding District Service Award at this year's annual meeting. ... One of four recipients of the Detroit Chamber of Commerce's annual Summit Awards is **Marjorie Peebles-Meyers, MD,** Dearborn, head of the medical unit at Ford Motor Company. The Summit Award is presented for contributions to the community. She is a former delegate to MSMS ... **Reed O. Dingman, MD,** Ann Arbor, has received the Honorary Award of the American Association of Plastic Surgeons. He was honored at the association's recent annual meeting in Chicago. ... Newly elected as president of the Southeastern Michigan Surgical Society is **Elle D. Aboulafia, MD,** Southfield. ... **Richard E. Dean, MD,** Grand Rapids, director of surgery at Michigan State University's College of Human Medicine community campus in Grand Rapids, has been named chairperson of the medical school's Department of Surgery. ... One of 20 resident physicians receiving a $1,500 Mead Johnson award from the American Academy of Family Physicians is **Henry Charles Barry, MD,** Lansing. Winners are chosen by the AAFP's Mead Johnson Awards Committee on the basis of scholastic achievement, leadership abilities and interest in family practice. ... **Joseph Wiener, MD,** Franklin, recently was named chief of pathology at Hutzel Hospital. In addition to his new duties at Hutzel, he will continue to serve as chairman of the Pathology Department at the Wayne State University School of Medicine and as pathologist-in-chief for Detroit Receiving Hospital-University Health Center. ... **Harvey V. Sparks, MD,** chairman of Michigan State University's Department of Physiology, has been named chairman of the National Board of Medical Examiners (NBME) Part I Physiology Test Committee. The board's corps of examiners is a component of the NBME examination system for the nation's MDs. ... Newly named to the Saint John Hospital Board is **Walter D. DiGiulio, MD,** Detroit. Doctor DiGiulio is a member of the hospital's Department of nuclear medicine where he specializes in thyroidology and nuclear cardiology. ... **Donald J. Cady, MD,** Saginaw, was recently appointed coordinator of medical affairs at St. Mary's Hospital there. He will be responsible for administrative coordination and advising on professional matters related to the medical staff. ... Upjohn Company directors have elected **Theodore Cooper, MD,** Kalamazoo, as vice-chairman of the board. Doctor Cooper will retain his previous responsibilities and in addition will be responsible for corporate legal administration. ... **Lawrence S. Lackey, MD,** Ecorse, has been appointed by Governor James Blanchard to the Hospital Capacity Reduction Corporation and its board of trustees. Doctor Lackey will represent community hospitals. ... Honored by both his peers and students at the University of Michigan Medical School is **William Burkel, MD,** Chelsea. Doctor Burkel received a grant for "outstanding professor-clinical years" at the medical school. He received a certificate and check for $1,000 from the Kaiser-Permanente Foundation. Winners of this award are selected by a committee consisting of both students and faculty. ... **Luiz F. P. DeMoura, MD,** Mount Clemens, was recently inducted into the American Society of Head and Neck Surgery at Palm Beach, Florida. ... **Samuel M. McMahon, MD,** Lansing, Chairman of the MSMS Committee on Continuing Medical Education Programming, received the President's Award of the American Lung Association.

Professional
INSTALLMENT LOANS

$15,000 TO $90,000

Decision In 24 to 48 Hours!

Same-Day Answer to Applications Received By Express Mail

- Deal Directly With Lender
- Deferred Payment Plans
- No Prepayment Penalty
- No Restriction on Use of Funds For:
  Investments
  Payment of Taxes
  Debt Consolidation
  Tax Shelters
  Pension Plan Contributions

Ask for Tom Todd

CALL TOLL FREE:
800-423-5025

Serving The Medical Profession Since 1966

WOODSIDE CAPITAL CORP.
National Headquarters
Woodside Capital Building
21424 Ventura Boulevard
Woodland Hills, California 91364

NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Renu F. Agarwal, MD — IM
100 Harrow Lane
Saginaw 48603

Silvio Aladjem, MD — OBG
252 E. Lovell St.
Kalamazoo 49007

Juan C. Alejos (Student)
3690 Berkshire Dr.
Birmingham 48010

Josephine F. Aloot, MD — IM/RHE
134 W. University #206
Rochester 48063

James A. Applegate, MD — FP
3181 Prairie, SW
Grandville 49418

Joseph M. Asprec, MD — GP
201 North Pine
Onaway 49965

Maria V. Avila, MD — P
15930 Cumberland
Riverview 48192

Muzaffar K. Awan, MD — GP/PM
8315 Grand River
Detroit 48195

Robert Badalament, MD — U
24645 Marine
East Detroit 48021

Kathleen M. Bauer, MD — EM
4640 S. Hagadorn Rd., A-5
East Lansing 48823

Pamela Benitcz, MD — GS
4201 St. Antoine
Detroit 48201

Victor A. Bernstam, MD — CLP
2736 Gloucester Way
Ann Arbor 48104

Kishore S. Bhende, MD — AN
7A Briarwyck Arms
927 N. Macomb
Monroe 48161

Carolyn Bird, MD — GPM/PH
1200 N. Telegraph
Pontiac 48053

Timothy Branigin, MD — PTH
1179 Tumbleweed Ct.
Flint 48504

A. Joseph Brough, MD — PTH
3901 Beaubien
Detroit 48201

Richard C. Brown, Jr., MD — P
131 E. Columbia #111
Battle Creek 49015

Gualberto D. Buzon, MD — R
830 S. Jefferson
Saginaw 48601

Alfonso Cardenas, MD — PTH
31 N. St. Joseph Ave.
Niles 49120

Thomas J. Carlson (Student)
1548 L. Spartan Village
East Lansing 48823

Michael Casher, MD — P
2200 Fuller Rd. #413B
Ann Arbor 48105

Thorvold W. Christiansen, MD — CDS/TS
1901 D Niles Ave.
St. Joseph 49085

Annamaria Church, MD — PD
33217 Kirby
Farmington 48024

Larry Dell (Student)
23090 Sussex
Oak Park 48237

Paul D. DeVito, MD — ORS
1000 Homer St.
Lansing 48912

Janet K. Dubeck — WSU
5200 Anthony Wayne Dr. #204
Detroit 48202

James L. Ecker, MD — RT/EM
Hackley Hospital
Muskegon 49443

Joe D. Eggebeen, MD — EM
3048 Howlett, SE
Ada 49301

Winifred A. Eshragh, MD — FP
121 Franklin, SE
Grand Rapids 49503

Sandra Faulkner-Shirley, MD — PTH
Edw. W. Sparrow Hosp.
Lansing 48900

Barry W. Feldman, MD — U
15901 W. 9 Mile Rd.
Southfield 48075

Jonathon R. Fiebing, MD — AN
1100 Sixth St.
Traverse City 49684

Niel A. Friedman, MD — PM
30554 Southfield Rd. #237
Southfield 48076

Paul B. Friedman (Student)
2802 Briarcliff
Ann Arbor 48105

Frank W. Garber (Student)
410 Kellogg #38
Ann Arbor 48105

Georges B. Ghafari — WSU
4632 Cadieux
Detroit 48224

Gordon G. Gibb, DO — EM
2601 Electric Ave.
Port Huron 48060

Roy C. Grekin, MD — D
U of M Dept/Derm
Ann Arbor 48109

Michael S. Grossman, MD — FP
829 Croix St.
Negaunee 49866

Vincent T. Guarnaccia, MD — GS/EM
800 E. Columbia
Mason 48854

Frederick C. Guenther, MD — OBG
415 Mecosta
Big Rapids 49307

James A. Guigelaar, MD — IM
2222 Pine St.
Jenison 49428

Bradley R. Hall (Student)
2368 Holmes
Hamtramck 48212

Paul S. Harkaway, MD — IM
3855 Greenbrier #332B
Ann Arbor 48105

Kim C. Hendrick, MD — FP
3280 N. Elms St. E
Flushing 48433

Marion Hoelzer, MD — EM
18135 Buckingham
Birmingham 48009

Martin F. Hoffman, MD — FP
50680 CR 652 Mattawan Rd.
Mattawan 49071

Terry W. Hood, MD — NS
U of M Hosp. Dept./Neurosurgery
Ann Arbor 48109

Robert J. Hoolsema, MD — AN
2663 Boston, SE
Grand Rapids 49506

Continued on page 410

Transportation:

Delivery of patient specimens is the first step in providing laboratory testing services. The Advance Medical & Research Center, Inc. transportation department provides specimen pick-up and twenty-four-hour turnaround time of test results by employing more than 60 couriers, daily air flights and report transmission by high-speed teleprinters.

ADVANCE MEDICAL & RESEARCH CENTER, INC.

1270 Doris Rd. • Pontiac, Michigan 48057 • (313) 373-9120

Branches: Allen Park, Alpena, East Jordan, Flint,
Grand Rapids, Kalamazoo, Lansing, Monroe, Traverse City

Serving the medical profession since 1963

Roger S. Howard, MD — GS
44199 Dequindre #102
Troy 48098

Julius J. Huebner, MD — ORS
3775 Greenbrier #251-B
Ann Arbor 48105

Doug Jackson, MD — FP
802 S. Main #7
Cheboygan 49721

Maureen C. Jensen — WSU
3785 Brewster
Dearborn 48120

Anthony L. Joseph — WSU
33110 Joy Rd.
Livonia 48150

Jin B. Jyung, MD — OBG
820 Lester Ave.
St. Joseph 48085

Irvin Kappy, MD — PD
23133 Orchard Lake Rd.
Farmington 48024

Walter Korytowsky, MD —
D/PD
1514 Fourth St.
Jackson 49203

Peter A. Kuhl, MD — FP
2233 Estelle Dr., SE
East Grand Rapids 49506

Leonard P. LaCivita (Student)
30911 Rayburn
Livonia 48154

Patricia Ann LaHale, MD — PM
1043 Island Dr. Ct. #106
Ann Arbor 48105

Stuart P. Landay (Student)
810 W. Huron #1
Ann Arbor 48103

Claude D. Lees, MD — TS
22151 Moross #228
Detroit 48226

Loretta Leja, MD — FP
802 S. Main #7
Cheboygan 49721

Marvin P. Lerner, MD — FP
2510 R.T. Longway
Flint 48503

Danute Leveckis, MD — OPH
560 W. Mitchell
Petoskey 49770

Marc A. Levison, MD — GS
3990 John R.
Detroit 48201

William K. Y. Loh, MD — AN
1019 S. Collon Dr.
Bad Axe 48413

John Lomas (Student)
2259 Stone
Ann Arbor 48105

George Mackey, Jr., MD — IM
3044 W. Grand Blvd.-GMC
Detroit 48202

Kathleen McCarroll, MD — DR
4871 Malibu Dr.
Bloomfield Hills 48013

George E. McClane — (Student)
335 Bostwick, NE
Grand Rapids 49503

Harry C. McDonald, MD — FP
146 S. Johnson
Pontiac 48053

Dennis E. McGeath, MD — PD
560 W. Mitchell
Petoskey 49770

Michael K. McLeod, MD — GS
3163 Norwood St.
Ann Arbor 48104

Continued on page 412

HEALTH PROFESSIONALS!

The Army Medical Department represents the largest comprehensive system of health care in the United States and offers unique advantages to the student, resident, and practitioner in the following professions:
- Physician
- Dentist
- Veterinarian
- Optometrist
- Psychologist
- Nuclear Scientist
- Environmental Scientist
- Civil Engineer
- Podiatrist
- Audiologist
- Pharmacist
- Laboratory Scientist

As an Army Officer, you will receive substantial compensation, an annual paid vacation, and participate in a remarkable non-contributory retirement plan.
For more information just fill out the attached form and mail. Or call: (313) 668-2190/2191. (Collect calls accepted.)

PLEASE SEND MORE INFORMATION ABOUT OPPORTUNITIES
IN THE ARMY MEDICAL DEPARTMENT
MAIL OR CALL:
ARMY MEDICAL DEPT., PERSONNEL OFFICE, 200 E. LIBERTY ST.,
ANN ARBOR, MI 48107, PH: (313) 668-2190/2191

NAME ____________________ AGE ____
ADDRESS ____________________
ZIP ____________ PHONE (AC) ____________
SCHOOL ATTENDED/ATTENDING ____________
GRADUATION DATE ____________ DEGREE ____________
SPECIALTY AREA OF INTEREST ____________

1953.

- General Dwight D. Eisenhower was inaugurated President of the United States; his vice president was Richard M. Nixon.
- The Korean armistice was signed to end the Korean War.
- Not one home owned an electronic calculator or color TV.
- It cost 3¢ to mail a letter.
- The Studebaker was the "new American car with the European look."
- Jacqueline Bouvier was engaged to U.S. Senator John F. Kennedy; **and**
- **the Stratton Agency began serving the Michigan State Medical Society!**

We have appreciated your participation and support over the past 30 years. If you would like additional information about our services, we would be happy to hear from you.

STRATTON-CHEESEMAN & ASSOCIATES, INC.
1305 Abbott Road, P.O. Box 1563
East Lansing, Michigan 48823

800-292-1926

NEW MEMBERS/continued

Raouf A. Mikhail, MD — GS/ON
G-1090 N. Ballenger A
Flint 48504

Sandy Milgraum, MD — D/PD
2180 St. Francis St. #F142
Ann Arbor 48104

Ruth L. Mills, MD — FP
28 Jefferson
Pontiac 48058

Gary Mueller — (Student)
404 N. Thayer #2
Ann Arbor 48104

Jesus Neri, Jr., MD — FP
P.O. Box 68
Posen 49776

Robert M. Nicholson III, MD — AN
216 Bronson Medical Center
Kalamazoo 49007

John K. Niparko, MD — OTO
1056 N. Maple
Ann Arbor 48103

Allan D. Olson, MD — PD
Henry Ford Hosp. PD Dept.
Detroit 48202

David L. Osher, MD — R
25334 Circle Dr.
Southfield 48075

Randolph R. Otto (Student)
2435 Laurelwood Circle
Ann Arbor 48104

David T. Overton, MD — EM/IM
6160 Lantern Lane
Birmingham 48010

Robert H. Painter, MD — IM/AN
10350 Orchard Lane
Lakeview 48850

Sheryl L. Parks, MD — OBG
12800 E. Warren
Detroit 48215

Anthony Parnello, MD — OBG
701 N. Logan
Lansing 48915

Taru P. Patel, MD — FP
50 College Ave., SE #215
Grand Rapids 49503

John M. Pelachyk, MD — D
Henry Ford Hosp. Derm. Dept.
Detroit 48202

Eric L. Peterson, MD — GS
6001 W. Outer Dr.
Detroit 48235

Steven A. Portney (Student)
1139 Nielson Ct. #1
Ann Arbor 48105

E. G. Raj, MD — IM
3040 Monikon Ct. #7
Flint 48504

Paul T. Rajasekhar, MD — IM/P
Alpena Gen. Hosp.
Alpena 49707

V. Nadimpalli Raju, MD — P
1560 E. Sherman Blvd. #155
Muskegon 49444

Judith G. Rapp, MD — AN
32950 Five Mile Rd.
Livonia 48154

Randall S. Reimer, MD — IM
118 S. Huron
Ypsilanti 48197

Roy A. Ringenberg, MD — IM
2 Hospital Drive
Berrien Center 49102

Eric J. Robb, MD — AN
5060 Lakeshore Rd.
Port Huron 48060

Philip G. Robinson, MD — PTH
175 College St.
Battle Creek 49017

Valda L. Robinson, MD — PD
22341 W. Eight Mile Rd.
Detroit 48219

Steven J. Rowe (Student)
504 Lawrence #1
Ann Arbor 48104

Panna Roy, MD — P
4484 Janice Lee Dr. A-106
Okemos 48864

Michael B. Rozboril, MD — IM/RHU
24555 Haig
Taylor 48101

Arthur F. Saari, MD — PUD/IM
1414 W. Fair Ave. #221
Marquette 49855

Anjum S. Sadiq, MD — PM
2520 S. Telegraph Rd. #201
Bloomfield Hills 48013

Martin D. Saine, MD — D
1308 Maryland
Grosse Pte. Park 48230

James R. Sattler, MD — R
1501 W. Chisholm
Alpena 49707

Indira Sawhney, MD — IM/GP
3261 Bloomfield Park
West Bloomfield 48033

Thomas W. Schacht, MD — IM
12256 Quincy St.
Hancock 49930

Judith Schartenberg, MD — OPH
24555 Haig
Taylor 48180

John B. Schroeder, MD — FP
4005 Orchard Dr.
Midland 48640

Timothy J. Schmale, MD — AN
888 Waddington
Birmingham 48009

Richard J. Schubatis, MD — IM
15543 Golfview
Livonia 48154

John Schurman II, MD — ORS
Henry Ford Hosp.
2799 W. Grand Blvd.
Detroit 48202

Thomas A. Segall, MD — P
1327 Jones Dr.
Ann Arbor 48105

Shiraz H. Shariff, MD — IM/CD
4364 State St.
Saginaw 48603

Mark R. Shebuski, MD — FP/EM
609 Sheldon Ave.
Houghton 49931

Steven M. Shumer, MD — D
26206 W. 12 Mile Rd. #205
Southfield 48034

Joseph R. Spiegel, MD — OTO
2886 Eisenhower Pkwy.
Ann Arbor 48104

Terry M. Silver, MD — R
1405 W. Ann, Box 13
Ann Arbor 48109

Charles E. Sisung, MD — PD
P.O. Box 325
Manchester 48158

Randy Smejkal, MD —
621 John St. Apt. P
Kalamazoo 49007

James B. Smith, Jr., MD — U
8385 Woodcrest Dr. #2
Westland 48185

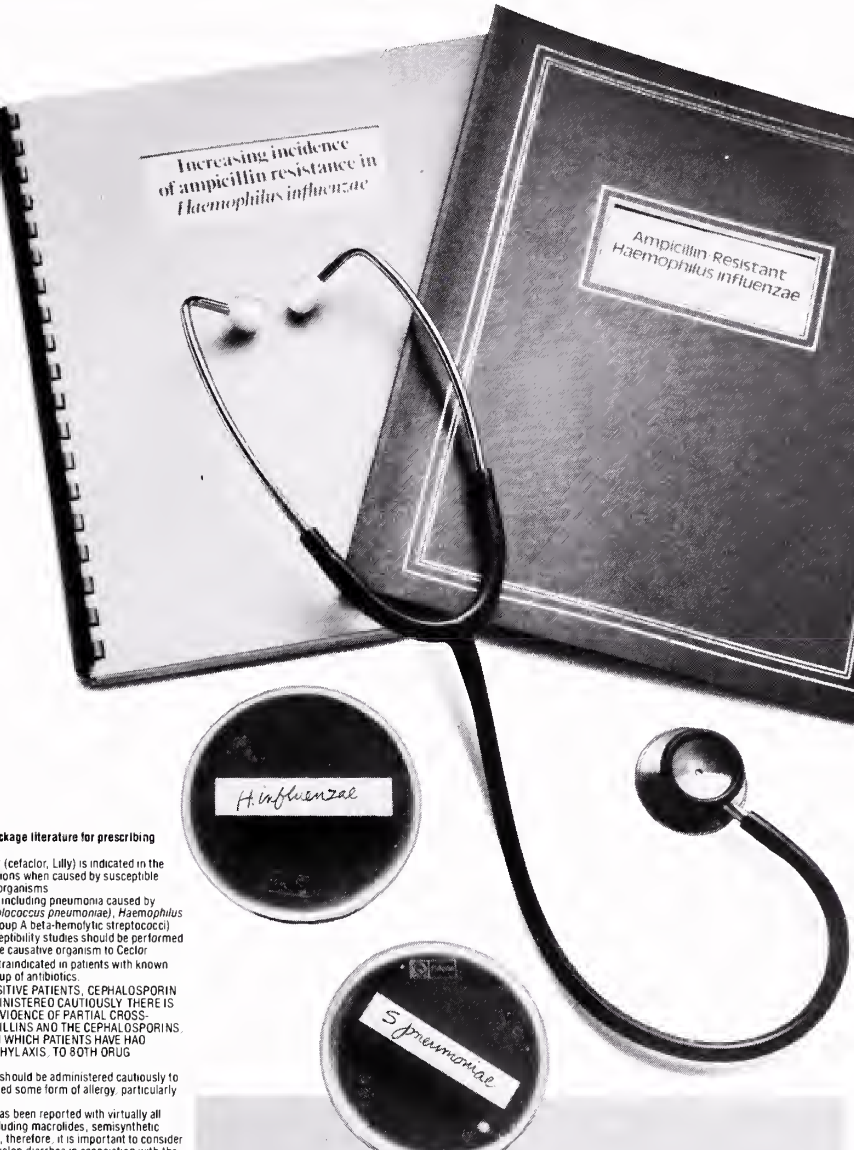
Susan V. Soliven, MD — EM
2333 Biddle Ave.
Wyandotte 48192

Errol I. Soskolne, MD — PD
2522 Packard Rd.
Ann Arbor 48104

Dennis W. Spender, MD — IM
Doctor's Park
Escanaba 49829

Continued on page 423

An added complication... in the treatment of bacterial bronchitis*


Increasing incidence of ampicillin resistance in *Haemophilus influenzae*
Ampicillin Resistant Haemophilus influenzae
H. influenzae
S. pneumoniae

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.$^{1-6}$

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms.

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

---

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., *8*:91, 1975.
2. Antimicrob. Agents Chemother., *11*:470, 1977.
3. Antimicrob. Agents Chemother., *13*:584, 1978.
4. Antimicrob. Agents Chemother., *12*:490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II:880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., *13*:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

© 1982, ELI LILLY AND COMPANY

Lilly

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

300035

CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, (517) 337-1351.

Date: August 13-17, Tutorial on Direction Action Thrust Manipulative Therapy. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU College of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A306 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

Date: August 18-19, Regional Anesthesia: Anatomy and Techniques. Location: Detroit Medical Center. **Sponsor:** Wayne State University School of Medicine Departments of Anesthesia and Anatomy. **Contact:** Wayne State University School of Medicine, Continuing Medical Education, 4201 St. Antoine, Detroit 48201, (313) 577-1180. **Approved for:** 12 hours of Category I Credit.

Date: August 24-27, Advances in the Management of Infectious Diseases. Location: Grand Hotel, Mackinac Island. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 10 hours of Category I Credit.

Date: August 29-31, Controversies in Obstetrics and Gynecology. Location: Grand Hotel, Mackinac Island. **Sponsor:** American College of Obstetricians and Gynecologists. **Contact:** Patience A. Schenck, Division of Education, American College of Obstetricians and Gynecologists, 600 Maryland Avenue, SE, Washington, DC 20024. **Approved for:** 16 hours of Category I Credit.

Date: September 7-9, Seventh Annual Course in Diagnostic Ultrasound. Location: Towsley Center. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 15 hours of Category I Credit.

Date: September 8, Pediatric Endocrinology. Location: St. John Hospital. **Sponsor:** CME Committee of St. John Hospital. **For:** Interested physicians. **Cost:** $90.00. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road, Detroit 48236 (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: September 8-9, Michigan Hypertension Update — 1984. Location: Bay Valley Inn. **Sponsor:** University of Michigan Medical School. **Contact:** Towsley Center, University of Michigan Medical School, (313) 763-1400. **Approved for:** 7 hours of Category I Credit.

Date: September 8-12, Fundamental of Muscle Energy. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU College of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A306 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

Date: September 10-12, Hemodynamic Monitoring. Location: Towsley Center. **Sponsor:** University of Michigan Medical School Dept. of Pathology and Office of Continuing Medical Education. **Contact:** Office of CME, Towsley Center, Box 057, U-M Medical School, Ann Arbor, 48109, (313) 763-1400. **Approved for:** 14.5 hours of Category I Credit.

Date: September 12, Primary Care Medicine: An Exciting Frontier Revisited. Location: Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit, 48202, (313) 876-3073. **Approved for:** 16 hours of Category I Credit.

Date: September 13-14, 30th Annual Michigan Association of Blood Banks. Location: Westin Hotel, Detroit. **Sponsor:** Pontiac General Hospital. **Contact:** Florene Luke, Michigan Association of Blood Banks, 15948 Hilton Road, Southfield, 48075 (313) 559-6309. **Approved for:** 11 hours of Category I Credit.

Date: September 17-19, Current Concepts in the Management of Arrhythmias and Coronary Heart Disease. Location: Towsley Center. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010, (313) 763-1400. **Approved for:** 20.5 hours of Category I Credit.

Date: September 19, New Perspectives in the Treatment of Heart Failure. Location: Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202, (313) 876-3073. **Approved for:** 6 hours of Category I Credit.

Date: September 21-23, Tutorial on Myofascial Release Technique. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A306 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 24 hours of Category I Credit.

Date: September 24-25, New Approaches to Patient Care in Diabetes: Promoting Self-Care Behavior. Location: Towsley Center. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010, (313) 763-1400. **Approved for:** 13.5 hours of Category I Credit.

Date: September 29, You Could go to Court: Avoiding Legal Entanglements. Location: Towsley Center. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor, 48109-0010, (313) 763-1400. **Approved for:** 6 hours of Category I Credit.

Date: October 6-10, Advanced Muscle Energy Tutorial (above diaphragm). Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A306 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

Date: October 12-13, Parenteral and Enteral Nutrition. Location: Towsley Center. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010, (313) 763-1400. **Approved for:** 9 hours of Category I Credit.

Date: October 17, Influencing Unfavorable Pregnancy Outcomes. Location: St. John Hospital. **Sponsor:** CME Committee of St. John Hospital. **For:** Interested physicians. **Costs:** $90.00. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road, Detroit 48236 (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: October 19-20, Digital Subtraction Angiography: 1984. Location: Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit, 48202, (313) 876-3073. **Approved for:** 14 hours of Category I Credit.

Date: October 19-21, American Academy of Pediatrics-Michigan Chapter, Scientific Program. Location: Grand Traverse Resort Complex. **Sponsor:** Michigan Chapter, American Academy of Pediatrics. **For:** Pediatrics, Family Practice, DOs and Health Providers for Children. **Contact:** P. Miles Tieman, 32245 Hearthstone, Farmington Hills, 48018. **Approved for:** 7 hours of Category I Credit.

Date: October 23, Infectious Disease Update. Location: Towsley Center. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010, (313) 763-1400. **Approved for:** 6 hours of Category I Credit.

Continued on page 418

BALANCED CALCIUM CHANNEL BLOCKADE!

CARDIZEM®
(diltiazem HCl)
balances
potent
coronary
vasodilation
with a low
incidence of
side effects

Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:

1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED
CALCIUM CHANNEL BLOCKER

Please see full prescribing information on following page.

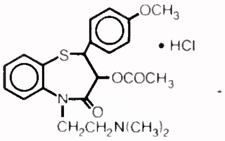
2/84

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy)-5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+)-cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral/LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 4/1/84

Another patient benefit product from
PHARMACEUTICAL DIVISION
MARION
LABORATORIES, INC.
KANSAS CITY, MISSOURI 64137

Sherman E. Andrews, MD
Kalamazoo

Sherman E. Andrews, MD, Kalamazoo, died on May 18, at the age of 82. Doctor Andrews graduated from the University of Michigan Medical School in 1926. He was affiliated with Borgess and Bronson hospitals in Kalamazoo. Doctor Andrews served with the military at Camp Polk Hospital and Kennedy General Hospital from 1942 to 1946. He was a former delegate to the MSMS House of Delegates and former president of Kalamazoo County Medical Society.

Louis J. Bailey, MD
Southfield

Former chief of staff of Providence Hospital, Louis J. Bailey, MD, Southfield, died on May 26 at the age of 85. He graduated from the Detroit College of Medicine and also held a master of science degree from the University of Pennsylvania. Doctor Bailey was associated with Providence Hospital since the early '20s and was an instructor of clinical medicine at Wayne State from 1927 to 1946. He was past president of the Wayne County Medical Society and editor of the Detroit Medical News.

Alfred Ellison, MD
Okemos

Alfred Ellison, MD, Okemos, died on May 16. He was 64. Doctor Ellison graduated from the University of Texas Medical School in 1944. During World War II and the Korean Conflict he served in the US Navy. Doctor Ellison practiced pediatrics for 34 years, 12 in Bay City and 18 in Lansing. He was also a clinical professor in the Department of Pediatrics and Human Development at Michigan State University. He served on the MSMS CME Accreditation Committee.

Harold W. Gehring, MD
Southfield

Harold W. Gehring, MD, Southfield, died on May 13 at the age of 78. Doctor Gehring graduated in 1936 from the University of Michigan Medical School. He was an orthopedic consultant for Henry Ford Hospital's West Bloomfield clinic, former chief of staff for orthopedic surgery at William Beaumont Hospital and a member of the emeritus staff at Harper-Grace and Sinai hospitals.

Arthur Goldberg, MD
Bloomfield Hills

Former chief of staff of North Detroit General, Arthur Goldberg, MD, Bloomfield Hills, died on May 21. He was 74. Doctor Goldberg was born in Russia and graduated from Detroit College of Medicine in 1935. He founded North Detroit General Hospital and for more than 40 years was active on its board of trustees. Doctor Goldberg served in the US Army in World War II.

Lawrence A. Kroha, MD
Grosse Pointe

Lawrence A. Kroha, MD, Grosse Pointe, died on May 17 at the

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

1st FOR PROFESSIONAL PROTECTION EXCLUSIVELY

YOUR FIRST STEP TO FIRST QUALITY PROTECTION
CONTACT FIELD REPRESENTATIVES

Eastern Office
JOHN K. GALLOWAY, THOMAS A. WEISMAN, WAYNE M. BACKUS,
MARK A. TISDEL and CHARLES J. ROWE
6785 Telegraph Road, Suite 350, Birmingham, Michigan 48010
(313) 647-6640

Western Office
GEORGE J. HAWORTH
2600 Five Mile Road, NE, Suite 101
Grand Rapids, Michigan 49505
(616) 361-0863

DEATHS/continued

age of 76. He was a member of the original staff of Bon Secours Hospital and had been in family practice the last 47 years. Doctor Kroha was also medical director of the original Belmont Nursing Home, Harper Woods, for 15 years. He graduated from Wayne State University School of Medicine.

Pyong Tai Lee, MD
Rochester

Pyong Tai Lee, MD, Rochester, died on May 29. He was 59. Doctor Lee was a surgeon and program director at South Macomb Hospital. He was a member of the American College of Surgeons and the Detroit Surgical Association. Doctor Lee graduated from Severance Medical College, Seoul, Korea.

Clifford B. Loranger, MD
Grosse Pointe Farms

Clifford B. Loranger, MD, Grosse Pointe Farms, died on May 12 at the age of 83. Doctor Loranger graduated from Detroit College of Medicine in 1925. He became a surgeon at St. John, Cottage and Saratoga hospitals. He also taught anatomy at Detroit College of Medicine. Doctor Loranger spent 41 years as village clerk and health officer of Grosse Pointe Shores, serving longer than any other elected official in any of the Grosse Pointe communities.

Donald C. Rockwell, MD
Kalamazoo

Donald C. Rockwell, MD, Kalamazoo, died on June 14 at the age of 91. Doctor Rockwell graduated in 1920 from Northwestern University Medical School. He was affiliated with the Borgess and Bronson hospitals in Kalamazoo where he practiced ophthalmology. Doctor Rockwell was past president and treasurer of Kalamazoo County Medical Society.

L. John Salan, MD
Traverse City

L. John Salan, MD, Traverse City, died on May 26 at the age of 77. Doctor Salan graduated from Georgetown University School of Medicine. He was a general practitioner in Washington, D.C. and Montana before specializing in ophthalmology. Doctor Salan served for seven years as an instructor in minor surgery at Georgetown University School of Medicine. He also was a team physician for Plymouth High School for a number of years.

George W. Sewell, MD
Bloomfield Hills

George W. Sewell, MD, Bloomfield Hills, died on May 29. He was 94. Doctor Sewell graduated from Detroit College of Medicine in 1912. He became a professor of urology at Detroit College of Medicine and chief of urology at both Harper and Detroit Receiving hospitals. Doctor Sewell also practiced in downtown Detroit and in Pleasant Ridge until his retirement in 1974.

Robert F. Trescott, MD
East Lansing

Robert F. Trescott, MD, East Lansing, died on May 9. He was 66. Doctor Trescott was an obstetrician and gynecologist in the Lansing area from 1945-1976. He served as a Captain in the Army Medical Corps during World War II, including one year in Europe. Doctor Trescott graduated from the University of Michigan Medical School and did postgraduate work in Tennessee, at Harvard Medical School and at Sparrow Hospital in Lansing.

Jay D. Vyn, MD
Grand Rapids

Jay D. Vyn, MD, Grand Rapids, died on June 16. He was 94. Doctor Vyn graduated from University of Michigan Medical School in 1911. Following postgraduate work at St. Luke's Hospital, Chicago from 1911 to 1913 he was in practice in General Surgery for 53 years. He was affiliated with Butterworth Hospital.

CATEGORY I/continued

Date: October 24-25, New Solutions to Clinical Problems in Allergy. Location: Towsley Center. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor, 48109-0010, (313) 763-1400. **Approved for:** 12.5 hours of Category I Credit.

Date: October 25-27, 15th Annual International Symposium on Implant Surgery for the Hand and Upper Extremity. Location: Blodgett Memorial Medical Center and Amway Grand Plaza Hotel, Grand Rapids. **Sponsor:** American Society for Surgery of the Hand. **Contact:** Alfred B. Swanson, MD, 290 Blodgett Professional Building, 1900 Wealthy Street, SE, Grand Rapids 49506 (616) 774-7294. **Approved for:** 19 hours of Category I Credit.

Date: October 25-27, Magnetic Resonance and Ultrasound Physics Continuing Education Course. Location: Towsley Center. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, Ann Arbor 48109, (313) 763-1400. **Approved for:** 6 hours of Category I Credit.

Date: October 26-28, Manual Medicine Principles Applied to the Extremities. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A306 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 24 hours of Category I Credit.

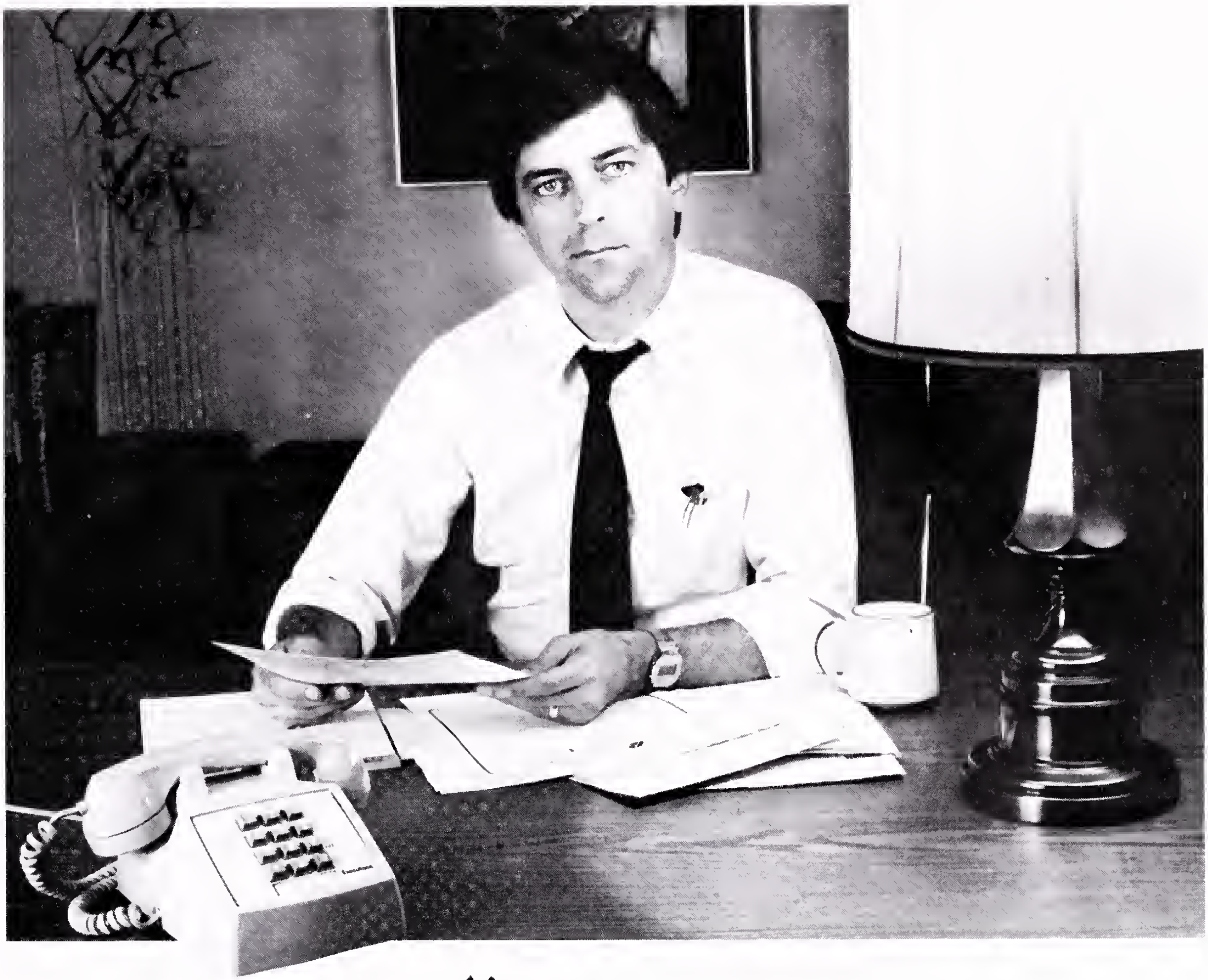
Date: October 27, Annual Meeting of Michigan Neurological Association. Location: Botsford Inn, Farmington. **Contact:** Raymond B. Bauer, MD, 4201 St. Antoine 6G, Detroit 48201 (313) 494-4281. **Approved for:** 4 hours of Category I Credit.

Date: November 3, Tenth Annual Symposium, Child and Adult Analysis: Mutual Contributions. Sponsor: Michigan Psychoanalytic Society. **Contact:** Evangeline J. Spindler, MD, Chairman, 16310 West Twelve Mile Road, Suite 204, Southfield, 48076, (313) 557-8633. **Approved for:** 3 hours of Category I Credit.

Date: November 8-10, Laser Bronchoscopy, A Practical Course with Hands-on Experience. Location: Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit, 48202, (313) 876-3073. **Approved for:** 14 hours of Category I Credit.

Date: November 13, 14 & 15, Annual Scientific Meeting. Location: Hyatt Regency Dearborn. **Sponsor:** Michigan State Medical Society. **For:** All interested physicians. **Contact:** MSMS headquarters (517) 337-1351. **Approved for:** Maximum of 18 hours of Category I Credit.

Date: November 14, Alcoholism. Location: St. John Hospital. **Sponsor:** CME Committee of St. John Hospital. **For:** Interested physicians. **Cost:** $90.00. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road, Detroit 48236 (313) 343-3877. **Approved for:** 8 hours of Category I Credit.



"...Your financial security specialist is on call"

American Physicians Life believes a physician's financial security deserves specialized attention. That's why our products and services are designed with the doctor in mind. Our comprehensive portfolio of services, including life insurance, professional disability income coverage, qualified plans and tax-deferred annuities, is customized to meet your personal financial planning needs as well as those of your professional corporation.

Let American Physicians Life secure your financial planning program—that's our specialty!

Call today for the financial security specialist in your area.

AMERICAN PHYSICIANS LIFE
Bates Drive, P.O. Box 281
Pickerington, Ohio 43147
Telephone (614) 864-3900

Toll-free in Ohio, 1-800-282-7515
Toll-free outside Ohio, 1-800-742-1275

Do you know

a physician with problems of alcoholism, drug abuse, emotional illness or other difficulties which interfere with his or her ability to practice medicine?

If so, please contact your MSMS Program to Assist Impaired Physicians through Katie Brewbaker at MSMS headquarters, (517) 337-1351.

MSMS, MSMS/A, AMA, and medical assistants

Sept. 19 — MSMS Board of Directors meeting, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Oct. 25 — MSMS Leadership Conference, Long's Convention Center, Lansing, contact: William Madigan, MSMS headquarters.

Nov. 13-15 — MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn, contact: Sherry Fent, MSMS headquarters.

Nov. 21 — MSMS Board of Directors meeting, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Dec. 2-5 — Interim meeting of AMA House of Delegates, Honolulu, Hawaii, contact: Bruce Ambrose, MSMS headquarters.

Other meetings

August 9-12 — Michigan Psychiatric Society Scientific Meeting, Grand Traverse Resort, contact: MPS (313) 552-8666.

August 22-24 — Annual Meeting, Michigan Health Officers Association, Traverse City, contact: Bruce B. Bragg, President, MHOA, PO Box 24143, Lansing 48909.

September 22-23 — Fall Meeting Michigan Society of Anesthesiologists, Amway Grand Plaza, contact: Caroline Rich, MSMS headquarters, East Lansing.

September 25-26 — 17th Annual Great Lakes Cancer Nursing Conference, Lansing Hilton Inn, contact: American Cancer Society Michigan Division, Inc.

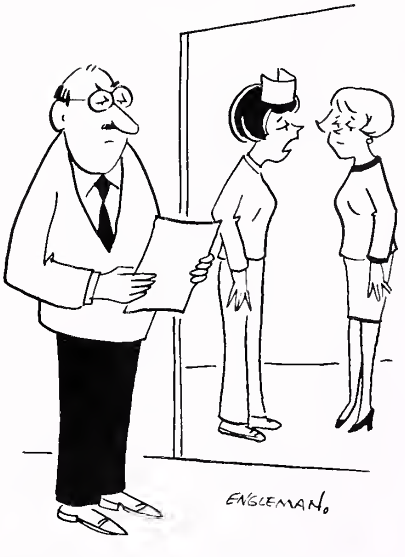
October 11-14 — ACP/MSIM Annual Regional Scientific Meeting, Boyne Highlands Resort, Harbor Springs, sponsored by Michigan Chapter, American College of Physicians in association with Michigan Society of Internal Medicine, contact: Arnold R. Axelrod, MD, FACP, Department of Medicine, Sinai Hospital of Detroit, 6767 West Outer Drive, Detroit 48235 (313) 493-5780.

October 12 — 1984 MDA Oral Cancer Symposium, Delta College University Center, contact: Jamie DePolo, Michigan Dental Association, 230 N. Washington Sq., Suite 208, Lansing 48933.

October 19 — 35th Anniversary Celebration of American Academy of Pediatrics, Grand Traverse Resort Village, contact: P. Miles Tiernan, Executive Secretary — MDAAP, 32245 Hearthstone, Farmington Hills, 48108.

October 27 — Annual Meeting of Michigan Neurological Association, Botsford Inn, Farmington, contact: Raymond B. Bauer, MD, 4201 St. Antoine 6G, Detroit 48201 (313) 494-4281

November 7-9 — Occupant Protection and Alcohol Countermeasures, Boyne Mountain, contact: Michigan Life Savers, Office of Highway Safety Planning, 111 S. Capitol, Lower Level, Lansing 48913.



"He never forgets your mistakes . . . he has a memory like a computer chip!"

PRACTICES FOR SALE

FAMILY PRACTICE—Mt. Clemens area. Beautiful equipment and office furniture. Practice is within large medical complex with complete radiology and blood work facilities. 2000 sq. ft.

MEDICAL PRACTICE — Houston-Whittier area. Office well cared for and equipment in good condition. **Doctor anxious to sell!**

FAMILY PRACTICE — St. Clair Shores area. Well-established. Has rental income, fantastic terms and a lab connection. **GREAT EARNINGS!**

FAMILY PRACTICE—Redford area. Excellent equipment and office furniture. Well-established practice. Building and rental included.

INTERNAL MEDICINE—East Detroit area. Big earnings, lots of equipment. **MUST SEE!**

MEDICAL PRACTICE—Lansing area. Industrial and family, good equipment. Also, building is optional. Great Opportunity.

Professional Practice Sales, Inc.
27208 Southfield Road
Lathrup Village, Michigan 48076
HERBERT SILVERMAN, BROKER
(313) 569-7336

Public health data system funded by Kellogg

A four-year grant of $3,120,021 has been awarded by the W. K. Kellogg Foundation to the Michigan Department of Public Health. The grant will be used to continue the use of a compatible, computerized data information system for all Michigan public health jurisdictions.

In announcing the grant, Doctor Gloria Smith, State Health Director, said that the funding of the project will enable the State Health Department to improve both the efficiency and effectiveness of public health services and may well serve as a model for other state health departments across the nation.

University Hospital

A group of 25 community and civic leaders have agreed to help raise $20 million in private donations needed to complete The University of Michigan Hospitals' Replacement Hospital Project.

The U-M Hospitals' $285-million Replacement Hospital Project (RHP) depends on three sources of funding; $173 million has come from the public sector through state appropriations and bond sales; the University has borrowed $92 million that the Hospitals will repay from future revenues; and $20 million is to be raised from private gifts.

The $20 million RHP gift campaign is a two-year effort that is part of the University's five-year, $160 million Campaign for Michigan.

LABORATORY OF CLINICAL MEDICINE

MID-MICHIGAN REFERENCE LABORATORY, II, Inc.
(517) 372-8180

1322 E. Michigan Ave.
Suite 211
Lansing, Michigan 48912

930 E. Mt. Hope Ave.
Lansing, Michigan 48910

2909 E. Grand River Ave.
Suite 104
Lansing, Michigan 48912

W. E. Maldonado, M.D.
Director

Robert B. Foy, Ph.D.
Chief Executive Officer

Ann E. Chernys, M.D.
John W. Dyke, Ph.D.
Dennis E. Freer, Ph.D.
John J. Gillespie, M.D.
Ronald N. Horowitz, M.D.
John R. Kateley, Ph.D.

LABORATORY OF CLINICAL MEDICINE
MID MICHIGAN REFERENCE LABORATORY

John J. Lyday, M.D.
Joseph R. Melvin, Ph.D.
Sandra K. Shirley, M.D.
Laurence R. Simson, Jr., M.D.
Susan M. Strate, M.D.
Irene K. Trombley, M.D.

REFERENCE LABORATORY FOR SPECIALIZED PROCEDURES
Specimen Pickup and Delivery of Test Results Daily
House calls are available upon Physician's request
Assignment is accepted from Medicare, Medicaid, Blue Shield and all other insurance carriers.

The rate for each classified advertisement in *Michigan Medicine* is 20¢ per word, with a minimum charge of $10.00. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

Positions Open

SENIOR STAFF PHYSICIAN THERAPEUTIC RADIOLOGY. Function as Senior Staff Therapeutic Radiologist in large hospital based multispecialty group practice. Engage in inpatient and outpatient practice. Perform full range of therapeutic radiology services. Engage in research, participate in teaching. Special Requirements: Must be Board Certified. Minimum Education Requirement: MD and four years of training including residency in Therapeutic Radiology or equivalent. 45 + hours per week. $90,000 per year. Send resumés to 7310 Woodward Avenue, Room 415, Detroit, 48202. Reference No. 21084. Employer paid ad.

POSITION AVAILABLE FOR OPHTHALMOLOGIST in well established eye clinic in downriver suburb of Detroit. Please send complete resume. Eye Clinic of Trenton, 2861 West Road, Trenton 48183.

MEDICAL ASSISTANT TO ASSIST IN examination and counseling of patients with ophthalmalogical problems, obtain histories and manage office. Accounting skills necessary and must be able to speak fluent Farsi and English. 1 year College req., 6 mos training in Ophthalmology, 6 mos experience. 8 to 5 , Mon. - Fri. $36,000 a year. Employer paid ad. Send resumes to 7310 Woodward Avenue, Room 415, Detroit 48202. Ref. No. 16484.

ASSISTANT DIRECTOR OF INTERNAL MEDICINE Education position available. 600-bed, university-affiliated hospital in the Midwest with a large Internal Medicine Residency Program seeks a Board Certified Internist (subspeciality not required) to teach Internal Medicine to residents and medical students and to assist the program director with administrative matters. University faculty appointment. "State of the Art" hospital facility. Excellent benefit package. Equal Opportunity Employer. Mail CV to: Administrative Director, Medical Education, Hurley Medical Center, One Hurley Plaza, Flint 48502.

INSTRUCTOR IN CARDIOLOGY WANTED to participate in the general medicine and subspecialty teaching rounds of the Department, specifically in cardiology; conduct conferences and seminars for medical students, clinical trainees and fellows; develop an active program in research; Requires MD degree and one year training as a resident/fellow in cardiology; 40 hours per week; $37,000 per year. Send resume to 7310 Woodward Avenue, Room 415, Detroit 48202. Ref. No. 19984. Employer Paid Ad.

WANTED SENIOR MEDICAL OPHTHALMOLOGIST full or part-time, for office in northwest Oakland County. Please respond to Box 62, Michigan Medicine, 120 W. Saginaw, East Lansing, 48823.

FAMILY PRACTICE (BATTLE CREEK) — Two man family practice seeking one or two physicians. Serving area of 100,000 with three open hospitals. Salary first year. Full partner after one year. Health insurance, disability insurance, pension and profit sharing plans, six weeks vacation. Inquire to Cinde VanDusen, Capital Avenue Medical, PC, 719 Capital Avenue SW, Battle Creek, 49015. Phone (616) 965-5188 (9 am-5 pm).

FAMILY PRACTITIONER — Seeking associate to join a well established Family Practice Clinic with x-ray and laboratory facilities. Excellent opportunity to be part of an expanding practice located in a water recreational area northeast of Detroit. Call (313) 794-9331 ask for Barbara, or write c/o Box 406, Algonac.

MEDICAL DIRECTOR. OPPORTUNITY FOR PHYSICIAN with experience in medical group practice administration to join established HMO in Madison, Wisconsin. Group Health serves 29,000 patients with its staff of 20 physicians and total staff of 180. Excellent salary and benefit program. This represents a rewarding opportunity to develop or progress your career in medical administration. Contact: John Mueller, Group Health Cooperative, 1 South Park St., Madison, WI 53715; (608) 251-4156.

FAMILY PRACTICE. RAPIDLY EXPANDING STAFF MODEL HMO in Madison, Wisconsin, has opportunities for additional family practice physicians. Competitive salary with excellent benefits and attractive practice setting. GHC is an established, rapidly growing HMO serving 29,000 patients. Current staff totals 180 employees, including 20 physicians. Contact: John Mueller, Group Health Cooperative, 1 South Park St., Madison, WI 53715; (608) 251-4156.

OB/GYN. GROUP HEALTH COOPERATIVE has 1984 opening for Board certified/eligible obstetrician and gynecologist. GHC is an established, rapidly expanding HMO. Staff enjoy a stable salary plus excellent benefit program including 5-6 weeks of time off plus $3,000 CME funding. Madison is a city of 200,000 population; University of Wisconsin; and 4 lakes. Contact: John Mueller, Group Health Cooperative, 1 South Park St., Madison, WI 53715; (608) 251-4156.

FAMILY PRACTIONERS, GENERAL PRACTITIONERS OR EMERGENCY MEDICINE PHYSICIANS — with practice experience wanted for free-standing urgent care centers located in the Central Michigan area. Excellent access to recreational areas. Associate and Medical Director opening immediately. Other vacancies opening in August or September of 1984. Salary negotiable plus fringe benefits. Send C.V. to Contemporary Medical Management, Incorporated, 401 South Euclid Avenue, Bay City 48706 (517) 667-0494.

PHYSICIANS NEEDED IN NORTH CENTRAL MICHIGAN — Family Practice, Urology, Pediatric and Orthopedic Surgery physicians needed in Grayling. This rapidly growing, beautiful resort area with a service population of approximately 40,000 has a 90 bed acute care hospital with attached 40 bed long term care unit. Family Practice, Internal Medicine, OB/GYN, Orthopedic Surgery and General Surgery physicians practice here at present (with several consulting specialists). Financial assistance is negotiable. Some opportunities exist within established practices. Well-established churches, country club, 34 miles of cross country ski trails, 200 miles of unrestricted waters for trout fishing, 200,000 acres of natural open country for snowmobiling and two major ski and winter sports areas 55 miles from Traverse City. Interested physicians, please send CV or call Barbara Lester, Mercy Hospital, 1100 Michigan Avenue, Grayling, 49738, (517) 348-5461.

GENERAL SURGEON, BOARD CERTIFIED or eligible, to join seven doctor family practice Clinic in Cloquet, Minnesota, a community of 12,000 (30,000 service area) located 20 minutes from Duluth-Superior. Clinic facility is located one block from modern, well equipped 77 bed hospital. Cloquet enjoys a stable economy (forest products). Additionally, our community is noted for its excellent school system. First year salary guarantee, paid malpractice, health and disability insurance, vacation and study time. Contact John Turonie, Administrator, Raiter Clinic, Ltd., 417 Skyline Blvd., Cloquet, MN 55720. Telephone (218) 879-1271.

MICHIGAN TECHNOLOGICAL UNIVERSITY HEALTH SERVICE seeks a replacement primary care physician. The health facility is a medically oriented, ambulatory service, servicing a university student population of 7,500. Annual student visits are approximately 12,000. Liberal fringes, meeting allowance, and vacation benefits complement a competitive salary and allow adequate enjoyment of the rural all-season recreation area. Contact David Schwalm, PA-C, Administrator, Michigan Technological University Health Service, Houghton, 49931, or call (906) 487-2435. Michigan Technological University is an Equal Opportunity Educational Institution/ Equal Opportunity Employer.

POSITIONS WITH THE STATE OF MICHIGAN — Currently taking applications for positions expected to be available in the future. Office locations now include Kalamazoo, Lansing, Southfield, and Traverse City. A board certified or board eligible psychiatrist needed for the Kalamazoo office, and internists with rheumatology or cardiology background desired for other offices. Beginning salary in low 60s with approximately 26% fringe benefits. An equal opportunity employer. All inquiries treated confidentially. For further details, please write: Harry D. Nesmith, MD, Chief Medical Consultant, Disability Determination Service, PO Box 30011, Lansing, 48909.

FAMILY PHYSICIAN: IMMEDIATE OPENING for a residency trained FP preferring small-town life style and interested in "whole person medicine from the Christian perspective" in a new office in the small college town of Hillsdale in southern Michigan. Write or call: Frederick L. Bean, MD, Hillsdale Family Practice, 111 South Howell, Hillsdale, 49242.

Positions Wanted

OPHTHALMOLOGIST AVAILABLE for locum tenens. Board certified. Also interested in full-time or part-time position. Contact: Box 39, Michigan Medicine, 120 W. Saginaw, East Lansing 48823.

Miscellaneous

GOOSE AND PHEASANT HUNTING. Private lodge, exclusive hunting on 800 acres. Gourmet meals. Lodging and guide service. Exclusive use with individual parties of 4-6 hunters. Total privacy for both business entertaining or for the sportsman in need of a quality hunt with friends. Reservations required. Brace Creek Lodge, 19425 Homer Road, Marshall 49068, (616) 781-7116 (Marshall), (517) 349-4251 (Okemos).

RENTAL — NORTHERN MICHIGAN'S HISTORIC HORTON BAY. Enjoy your vacation in an authentic Hemingway location. Shangri-la is a recently renovated cottage providing luxury accommodations overlooking beautiful Lake Charlevoix. Seven bedrooms, 3½ baths, large deck, fireplace, modern fully equipped kitchen. Ideal for golf, color tour, skiing or family groups. $750.00/week, $175.00/day, $175.00 security deposit. No pets. Inquire about off season rates. Call (616) 547-5124 or write Shangri-la Properties, 303 Central, Charlevoix, 49720.

IF YOUR TAX SHELTER HAS COLLAPSED and you are faced with recapture and/or other tax burdens, there may be viable solutions to the problem. When you participated in the tax shelter, you were probably too busy in your own practice to analyze it and relied on opinions of others. With a minimal amount of your time, you may turn this problem over to Liberson and Bock, P.C., attorneys, to analyze the possibility of recovery of your losses from responsible third persons. Liberson and Bock, P.C., attorneys at law, (313) 358-3010.

FOR SALE. MARCO ISLAND CONDOMINIUM, high-rise, on the beach. Beautiful Gulf of Mexico

view and island view. Two bedroom — two and one-half baths — approximately 2000 square feet. All amenities. For the discriminating buyer. Decorator furnished. Call area (313) 651-3871.

MICHIGAN: PRACTICE OPPORTUNITIES NOW AVAILABLE. Immediate income from well established practice, malpractice insurance, fully equipped office, with a congenial staff. Excellent opportunity for ambitious physician. For more information contact: Emergency Consultants, Inc., One Windemere Place, Petoskey 49770; 1-800-253-7092 or in Michigan 1-800-632-9650.

KIAWAH ISLAND, WILD DUNES BEACH and Racquet Club, Charleston, S.C. resorts. Choice 1-4 Bedroom Villas for rent. In prime locations, including ocean front. 25% owner discount. Brochure. (803) 556-6353.

SPORTFISHING CHARTERS AVAILABLE for salmon (Lake Michigan, Ludington and Frankfort) and walleye (Lake Erie, Monroe), aboard a 28 ' Bertram cruiser. All tackle provided. For details, call 1-313-625-2730.

MEDICAL OFFICE SPACE AVAILABLE the end of 1984. 2600 sq. feet of office space with shared waiting room. Linden Bristol Square, 5119 W. Bristol Road, Flint 48554. (313) 732-1620.

Rx PADS PRINTED to your specifications. $20.00 per thousand in pads of 100. $21.00 one time set up charge. Shipping additional. Small Craft Printing Company, 211 E. Kalamazoo St., Lansing, 48933 (517) 485-0553.

DOCTOR, YOU CAN'T BEAT THE QUALITY OR THE PRICE! Holter Monitor scanning service. Physician owned, trained and supervised. $35.00 for cassette reports; $45.00 for reel to reel reports; no contracts to sign. We can arrange for lease/purchase of Holter equipment. Why are you paying more and getting less? DCG Interpretation (313) 879-8860.

ATTENTION DOCTORS: We have previously owned medical, laboratory, office and x-ray equipment in excellent condition. We buy, sell, broker and repair. Office appraisals available by certified surgical consultants. Call Doctor Medical Resale at 313-569-4407, 9 AM-9 PM.

PHYSICIAN SIGNATURE LOANS TO $50,000. Up to 7 years to repay. No repayment penalties. Prompt, courteous service. Competitive fixed rate, with no points, fees or charges of any kind. Physicians Service Association, Atlanta, GA. Toll-free (800) 241-6905.

NEW MEMBERS/continued

Mark E. Stemplhar, MD — OPH
N10565 Grandview Ln.
Ironwood 49938

Barbara Supanich, MD — FP
P.O. Box 215
Eaton Rapids 48827

Dionisia A. Sy, MD — PD
1060 N. Cotting
Caro 48723

Dennis Szymanski, MD — NS
728 Pleasant St.
St. Joseph 49085

Walter J. Talamonti, MD — IM
17212 Flint
Melvindale 48122

Minda Tandoc, MD — IM
23738 Joy Rd.
Redford 48154

William E. Taylor II, MD — EM
2701 Washtenaw Ave.
Ann Arbor 48104

Madan Tellicherla, MD — PM
261 Mack Blvd.
Detroit 48201

Christopher L. Tisdel (Student)
1108 E. University
Ann Arbor 48104

Lawrence Tkakch, MD—ORS/SM
Henry Ford Hosp.
Detroit 48202

Robert Tomchik, MD — GPM/EM
418 W. Kalamazoo Ave.
Kalamazoo 48007

Allan L. Tompkins, MD — ORS
724 W. Franklin
Jackson 49203

H. Michael Topley, MD — U
560 W. Mitchell
Petoskey 49770

Neal R. Touran, MD — AN
560 W. Mitchell
Petoskey 49770

A. Timothy Truman, MD — PDC
1717 Haslett Rd.
East Lansing 48823

Laurence A. Ulrey, MD — ORS
44199 Dequindre #302
Troy 48098

Ronald J. Van Valkenburg, MD — CHP/PD
3727 Highgate
Muskegon 49441

David Verdier, MD — OPH/FP
515 Lakeside Dr., SE
Grand Rapids 49506

Jeffrey D. Webster (Student)
13409 Cooley
Detroit 48212

Leonard J. Weiss, MD — IM
6561 Wing Lake Rd.
Birmingham 48010

David J. Wendling, MD — FP
319 W. Delaware St.
Decatur 49045

Scott C. Wetzel, MD — OBG
347 Bostwick, NE #105
Grand Rapids 49503

Carl A. Williams, MD — OPH
2261 Hale
Detroit 48207

Ted Wojno, MD — OPH
1000 Wall St.
Ann Arbor 48109

Kathleen Yaremchuk, MD — OTO
19401 Hubbard Dr.
Dearborn 48126

Paul M. Zack, MD — CD
1751 Legend Lane
St. Louis, MO 63146

Ralph T. Zade, Jr., MD — PTH
44201 Dequindre
Troy 48098

Abdallah E. Zamaria, MD — P
19070 E. 10 Mile Rd.
East Detroit 48021

Joseph F. Zebari, MD — OBG
2316 S. Cedar St.
Lansing 48910

Gerald B. Zelelnock, MD — CDS/GS
U of M Med. Ctr. D2232 SACB
Ann Arbor 48104

Chito D. Zerrudo, MD — P
1249 Washington Blvd. #1715
Detroit 48226

Thanks to our advertisers

AMRC	409
American Physicians Life	419
Birmingham Motors Ltd.	400
Brown Pharmaceutical	387
Burroughs Wellcome	401
GTE/Telenet	395
Institute for Health Maintenance	386
Lab of Clinical Medicine	421
Eli Lilly & Company	413
MPMLC	396-397
MSMS Annual Scientific Meeting	IFC
MSMS Program to Assist Impaired Physicians	420
Marion Lab	415-416
Medical Protective	417
PICOM	402
Professional Practice Sales, Inc.	421
Roche Laboratories	IBC-BC
Smith Kline & French Lab.	403
Stratton-Cheeseman	411
US Army	410
Upjohn Company	404
Winthrop Breon	389-390
Woodside Capital Corporation	407

MSMS delighted with request to aid Ford contract talks

MSMS is excited about a new project which we believe has the potential to develop a long-term relationship between the Ford Motor Company and MSMS.

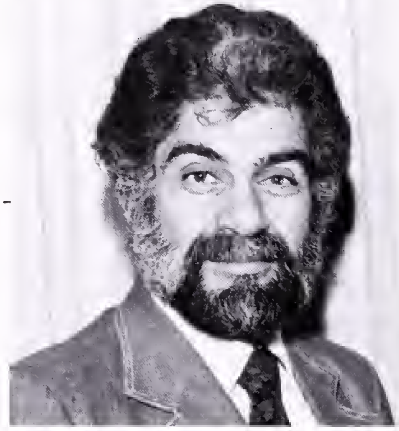
In June, Jack Shelton, manager of employee benefits for Ford Motor Company, requested that MSMS create an advisory panel of physicians to work with him and his staff in reviewing and modifying Ford's health care plan for salaried employees.

First time

This request marks the first time in recent memory that any industrial firm has sought expert medical advice in structuring health care benefits for its employees. The liaison should benefit Ford Motor company, its employees, and the physician members of the Michigan State Medical Society through the cooperative approach to providing quality medical and health care at a reasonable cost, rather than through the oft-tried and generally unsuccessful adversarial approach.

The current Ford plan, which covers approximately 800,000 salaried employees and dependents in the United States, is scheduled for renewal later this year. Our advisory panel has been charged with assisting in the development of a benefit package that provides high quality medical services with reasonable cost containment features.

The current Ford plan has several areas which have been troublesome or of special concern to the company in the past. We have been asked to address the following areas particularly but not exclusively: psychiatric and drug abuse treatment, organ transplants, rehabilitation services and custodial care, and acupuncture.



Louis R. Zako, MD
MSMS President

MSMS members long have chafed under the imposition of health care benefits packages which offered their services under arrangements forged entirely without their advice or consent. These arrangements even have included punitive conditions imposed upon our colleagues should they not agree to the terms of the health care delivery packages established minus their knowledge, let alone input.

We have repeatedly pointed out to both management and labor in the past the benefit to both sides if they were to seek medical input in negotiating health care benefits. But we were told in no uncertain terms that our input was neither desired nor in any fashion to be incorporated in the ritual known as collective bargaining.

The present MSMS advisory panel is to deal with only salaried health benefits. But in the auto industry, now facing negotiations at both Ford and General Motors on a new contract for hourly employees, what happens to health care benefits in one area inevitably has some influence on what happens in other areas.

This MSMS panel will, I believe, be able to provide Ford with the necessary expertise to develop a superior plan than the current one, a plan that provides necessary and appropriate health care benefits to employees at an affordable cost.

Serving on the panel, which I shall be chairing, are: Susan E. Adelman, MD, Southfield pediatric surgeon and immediate past president of the Wayne County Medical Society; Robert D. Allaben, MD, Detroit transplant surgeon; Melvin Bornstein, MD, Birmingham psychiatrist; Joseph C. Honet, MD, Detroit physical medicine and rehabilitation specialist; Samuel D. Indenbaum, MD, Detroit internist and rheumatologist; and Lawrence G. Morawa, MD, Dearborn orthopedic surgeon. Staffing this advisory panel will be Bruce W. Ambrose, who has been named executive director of MSMS to succeed Warren F. Tryloff.

MSMS hopes

The panel has several meetings scheduled for July and August in order to provide Mr. Shelton with our recommendations for modification of the current health plan by early September. Subsequently, we hope to deal with more basic restructuring of health care benefits with a view to long-term solutions to the company's problems in health care.

MSMS hopes that this precedent-setting liaison will benefit not only both Ford Motor Company and its employees but also MSMS. It may very well demonstrate to both labor and industry that health care benefits are too complex to negotiate from ignorance, and serve as a model for others in Michigan and throughout the United States to emulate.

I shall keep you posted on this note-worthy MSMS activity.

COMPLETE LABORATORY DOCUMENTATION[1-5]... EXTENSIVE CLINICAL PROOF

FOR THE PREDICTABILITY CONFIRMED BY EXPERIENCE

DALMANE® Ⓒ

flurazepam HCl/Roche

THE COMPLETE HYPNOTIC PROVIDES ALL THESE BENEFITS:

- Rapid sleep onset[1-6]
- More total sleep time[1-6]
- Undiminished efficacy for at least 28 consecutive nights[2-4]
- Patients usually awake rested and refreshed[7-9]
- Avoids causing early awakenings or rebound insomnia after discontinuation of therapy[2,5,10-12]

Caution patients about driving, operating hazardous machinery or drinking alcohol during therapy. Limit dose to 15 mg in elderly or debilitated patients. Contraindicated during pregnancy.

DALMANE® Ⓒ
flurazepam HCl/Roche

References: **1.** Kales J *et al*: *Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A *et al*: *Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A *et al*: *Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A *et al*: *Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol 3*:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **9.** Amrein R *et al*: *Drugs Exp Clin Res* 9(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol 3*:303-326, May 1981. **11.** Greenblatt DJ *et al*: *Sleep 5*(Suppl 1):S18-S27, 1982. **12.** Kales A *et al*: *Pharmacology 26*:121-137, 1983.

DALMANE® Ⓒ
flurazepam HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly* or *debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

DOCUMENTED IN THE SLEEP LABORATORY[1-5]...
PROVEN IN THE PATIENT'S HOME
FOR A COMPLETE NIGHT'S SLEEP
DALMANE®
Ⓘⓥ
flurazepam HCl/Roche
STANDS APART
15-MG/30-MG CAPSULES

See preceding page for references and summary of product information.

Copyright © 1984 by Roche Products Inc. All rights reserved.

MICHIGAN MEDICINE

mber 1984 The award-winning JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Vol. 83, No. 41

STACKS
225 0000000000 123184
SERIALS DEPT - LIBRARY
COLLEGE OF PHYS OF PHILA
19 SOUTH 22ND STREET
PHILADELPHIA, PA 19103

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA
SEP 27 1984

1984 MSMS Annual Scientific Meeting
'THE ART OF MEDICINE'

The Art of Medicine

Medicine combines art and science. The 1984 MSMS Annual Scientific Meeting offers 55 CME courses to help you improve your medical practice. Come and earn up to 18 hours of Category I Credit while you enhance your "art."

1984 MSMS ANNUAL
SCIENTIFIC MEETING
November 13-14-15, 1984
Hyatt Regency Dearborn

September 1984, Vol. 83, No. 41

MICHIGAN MEDICINE

About the cover

The artist takes up brush and paints to provide us with a representation of a medical practice scene. The drawing is one of three commissioned by MSMS to promote the 1984 MSMS Annual Scientific Meeting, with its theme, "the Art of Medicine." The artist is Steve Light of Lansing.

Special report

428 Everything you need to know to plan for the 1984 MSMS Annual Scientific Meeting is printed on pages 428-435 of this issue, including speakers, topics, times, and places. You'll find information on exhibitors, special events, key personnel and housing accommodations. You may register today for the courses of your choice with the form found on page 435. The earlier that's done, the better your chance of getting your preferences. If you take advantage of the opportunity provided to reserve your room at the Hyatt Regency Dearborn, you also will become eligible for two nights' free lodging plus dinner for two at the hotel's Giulio and Sons restaurant. Annual Scientific Meeting Chairman David R. Rovner, MD, extends his invitation to you on page 486. Don't miss this economical opportunity MSMS provides members to earn up to 18 hours of Category I credit in one convenient facility.

Features

439 MSMS leaders pay tribute to Warren F. Tryloff

450 Register today for the 1984 MSMS Public Affairs/Leadership Conference

458 Patients needed for studies at Lafayette Clinic, Detroit

460 Patients needed for studies at University of Michigan Clinical Research Center

Departments

427 Letters

448 MSMS/A; Evelyn Dykewicz

454 Medical newsfronts

463 Views; Susan Adelman, MD, and Sander Breiner, MD

469 New Members

470 News

472 Meetings

474 Category I meetings

479 Deaths

484 Classified ads

485 Board of Medicine actions

485 Ad index

486 President's page; David R. Rovner, MD

In next month's *Michigan Medicine*

A shocking percentage — national estimates are upwards of 40 percent, though the figure is not that high in Michigan — of physicians are not registered to vote! Of those who are, many do not choose to vote come election time. Thus, our October issue is dedicated to moving Michigan physicians to vote in the November presidential elections. The issues and the candidates will be discussed, with the object of helping Michigan physicians make intelligent choices. Don't miss a word!

Michigan State Medical Society

President	Louis R. Zako, MD, Dearborn Heights
President-elect	Richard J. McMurray, MD, Flint
Immediate Past President	Donald K. Crandall, MD, Muskegon
Secretary	Robert M. Leitch, MD, Battle Creek
Treasurer	Leland E. Holly, II, MD, Muskegon
Speaker	Gerald H. Mandell, MD, Detroit
Vice Speaker	Robert D. Burton, MD, Grand Rapids
AMA Delegation Rep.	Richard J. McMurray, MD, Flint

Board of Directors

Chairman	Thomas R. Berglund, MD, Portage
Vice Chairman	Carl A. Gagliardi, MD, Dearborn

District directors

District 1	Carl A. Gagliardi, MD, Dearborn James J. Humes, MD, Detroit Kenneth J. Ray, MD, Trenton Henry M. Domzalski, MD, Detroit Arthur A. Ulmer, MD, Grosse Pointe Shores Frank B. Walker, MD, Grosse Pointe Farms
District 2	Justin L. Sleight, MD, Lansing
District 3	William D. Walters, MD, Battle Creek
District 4	Thomas R. Berglund, MD, Portage
District 5	Harvey M. Andre, MD, Grand Rapids Kornelius Van Goor, MD, Grand Rapids
District 6	Richard L. Rapport, MD, Flint
District 7	Kenneth B. Herrington, MD, Bad Axe
District 8	Jack L. Barry, MD, Saginaw
District 9	Vickers C. Hansen, MD, Manistee
District 10	Charles L. Oppy, MD, Roscommon
District 11	Robert E. Paxton, MD, Fremont
District 12	Carl Hammerstrom, MD, Marquette
District 13	Kenneth E. Rowe, MD, Hancock
District 14	Marguerite Shearer, MD, Ann Arbor
District 15	Billy Ben Baumann, MD, Pontiac Frederick W. Bryant, MD, Royal Oak Joel W. Clay, MD, Mt. Clemens

Michigan State Medical Society
Bruce W. Ambrose, director

Committee on Publications
Harvey Andre, MD, Grand Rapids, chairman
Frederick W. Bryant, MD, Royal Oak
Vickers C. Hansen, MD, Manistee
Leland E. Holly II, MD, Muskegon
Richard L. Rapport, MD, Flint
Marguerite Shearer, MD, Dexter
Louis R. Zako, MD, Dearborn Heights

Editor
Judith Marr

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

MICHIGAN MEDICINE (ISSN 0026-2293) is the official journal of the Michigan State Medical Society, published under the direction of the Publications Committee. Published five times a month, 60 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $30.00; single copies, $1.50. Additional postage: Canada, $1 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to articles, news, exchanges, should be addressed to Judith Marr, advertising inquiries to Joyce Crum and address changes to Peg Berry, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517-337-1351.
©1984 Michigan State Medical Society

Laser use in Michigan

I just received my copy of the *Michigan Medicine* publication on the use of lasers in medicine. I realize that this special report was done by the physicians at Sinai Hospital in Detroit.

I am sure that many hours of work were done by each of the authors of these fine articles concerning the use of lasers in medicine. The article by Eugene Rontal, MD; Michael Rontal, MD, and H. John Jacob, MD is a very comprehensive study of the use of CO_2 lasers in otolaryngology.

However, there is a very active field of otology which is a subspecialty of otolaryngology. The use of the Argon laser in microsurgery of the middle ear for otosclerosis and chronic ear disease is a common practice, and I am dismayed that this field was ignored.

I was one of the principal investigators for the FDA at Providence Hospital for two years for approval of the use of the Argon laser. I have used the laser in every surgical case performed since I started using it. The approval from the FDA was given for general use of the Argon laser in February, 1983. I am sure that there are other otologists who feel as I do.

I am enclosing a reprint of an article concerning the *Use of the Argon Laser for Chronic Ear Disease and Otosclerosis* from the *Laryngoscope*, Vol. 93, No. 9, September 1983. Copies are available on request.

T. Manford McGee, MD
Greater Detroit Otologic Group, PC
Oak Park

I recently read the article entitled, "Laser and Anesthesia" by Milford Wenokur, MD, in the June issue of *Michigan Medicine*. As the box at the top of page 290 suggests, I would like to share with you the development of laser surgery within our department of dermatology at the University of Michigan Medical School. Both myself, Roy C. Grekin, MD, and my associate, Neil A. Swanson, MD, have been trained in and are currently using the carbon dioxide (CO_2) laser for the treatment of many cutaneous lesions. These include port-wine stain and other vascular lesions, recalcitrant warts, especially those on the plantar and periungual surfaces, keloids, tattoos and certain cutaneous neoplasms when indicated.

Thank you very much for allowing us the opportunity to share this information with our colleagues around the state. If you should need further information about our operation, please feel free to contact us at our offices.

Roy C. Grekin, MD
Instructor, Laser Surgery Unit
University of Michigan
Medical School

Merrell-Dow requests end to Bendectin Rx

Dear Doctor:

By the time you read this letter you may already have learned through the news media about the settlement of the massive litigation involving claims against Bendectin, formerly produced by Merrell Dow.

We remain confident in the safety of Bendectin. Unfortunately, we have been faced with escalating business costs which result from the complex legal system as it exists today in our country. This system affects all of us in industry, as well as you, the practicing physician. The settlement resolves this issue in the U.S.

In an effort to bring the Bendectin litigation to an end, we request that you no longer prescribe or dispense Bendectin from supplies that may still remain in your possession.

We appreciate your understanding of our action and invite any questions you may have.

David B. Sharrock
President and General Manager
Merrell Dow
Pharmaceuticals, U.S.A.
Cincinnati, OH 45215
513/948-9111

Doctor Battley remembers initiating pediatrics

Thank you for sending me a copy of the news pages appearing in the July Michigan Medicine. My wife, Grace, will place it along with letters and mementoes in a scrap book which she is preparing of the occasion of my elevation to the "peerage", namely, having a hospital department named after me.

I came to Port Huron in 1928 after several years study in various places - the Johns Hopkins Hospital, the New Haven Hospital at Yale University and the Henry Ford Hospital. There was then no pediatric department at Port Huron Hospital. Indeed, people hardly knew what pediatrics was all about.

Some thought it had something to do with feet - "peds" - a foot you know. We have just completed a considerable addition to the hospital including a new department of pediatrics, the very latest in pediatric construction. I am, indeed honored in having it named after me.

J.C.S. Battley, MD
Port Huron

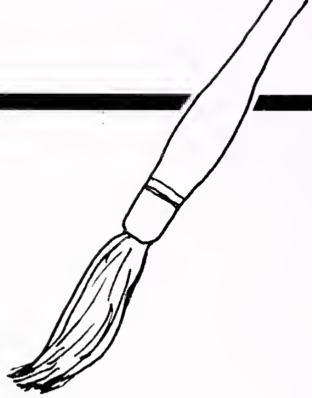
House of Delegates thank yous

Please convey my gratitude for the support the Michigan State Medical Society Delegates to the AMA gave me in Chicago in my successful candidacy for the AMA Auxiliary Speaker of the House.

The lovely cymbidium orchid corsage you sent me was most

Continued on page 444

Brush up your skills! Come to the 1984 MSMS Annual Scientific Meeting



Enhance the art of your medicine by attending the Nov. 13-14-15 MSMS Annual Scientific Meeting and earn 18 hours of Category I credit as you learn. MSMS is pleased to offer you a fine array of courses again this year at the Hyatt Regency Dearborn.

The theme of the meeting is "The Art of Medicine," chosen to emphasize the clinical, everyday practice of medicine which is the focus of the planning committee's efforts.

Each course at the Annual Scientific Meeting awards three hours of Category I credit and is presented by a specialty society, MSMS section, hospital or department of one of the medical schools. The cost is the same as last year ($18 per half-day course), and that includes a deli lunch in the exhibit hall.

Special events planned in conjunction with the meeting include a seminar on physicians' personal investments, first-ever clinical poster presentations accompanied by a wine and cheese reception, luncheons, dinners and receptions for nine specialty societies. In addition, 70 companies and organizations will discuss their products and services in the Great Lakes Exhibit Center.

MSMS Annual Scientific Meeting Chairman David R. Rovner, MD, East Lansing, and his committee invite you to review the schedules and course details on the following pages and then to register using the form on page 435.

Make your plans today!

At-a-Glance Schedule of ASM Special Events

Tuesday, November 13

7:30 AM	Great Lakes Exhibit Center Open
11:30 AM	Luncheon/speaker Specialty Society Presidents
	Luncheon/speaker Michigan Psychiatric Society Committee on Women's Issues
6:00 PM	Reception and dinner/dance Michigan Occupational Medical Association
7:00 PM	MSMS/PSG seminar, "Personal Financial Planning and Tax Advantaged Investing."

Wednesday, November 14

7:30 AM	Great Lakes Exhibit Center Open
9:00 AM	Meeting/luncheon Michigan Allergy Society
4:30 PM	Reception and presentation Clinical Posters
5:30 PM	Meeting, Reception and dinner Michigan Society of General Surgeons
6:00 PM	Reception and dinner Michigan Otolaryngological Society
	Reception and dinner/dance Michigan Academy of Family Physicians
	Reception Wayne State University Medical Alumni

Thursday, November 15

7:30 AM	Great Lakes Exhibit Center Open
6:30 PM	Reception and dinner Michigan Society of Colon and Rectal Surgeons
	Reception and dinner Michigan College of Nuclear Medicine Physicians

Alexander

Allaben

Bauer

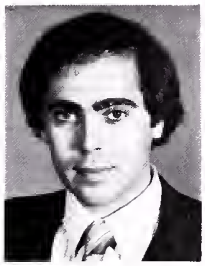
Bender

Berlin

Blum

Brody

Bryant


Ciullo

G. Dean

H. Dean

Dhabuwala

Here are courses, course directors

Tuesday Morning November 13

Robert K. Orr, Jr., DO
Basic Cardiac Life Support

(Repeated on Wednesday and Thursday mornings)

The course will include lectures and practical stations for teaching Basic Cardiac Life Support. The practical session will include hands-on teaching of cardiopulmonary resuscitation, obstructed airway in an unconscious and conscious victim, as well as CPR and conscious and unconscious airway obstruction for an infant.

Blaine C. White, MD
Brain Ischemia: Injury and Therapy

The pathophysiology of post ischemic-anoxic brain injury will be discussed. The evolving therapeutic modalities of calcium antagonists and iron chelation and radical scavengers will be presented.

Harold Perry, MD
Conservative Management of Early Breast Cancer

This course will discuss the combination of conservative surgery and radiation therapy favorable for breast cancer as an alternative to radical mastectomy. The role of adjuvant chemotherapy also will be discussed.

John F. Greden, MD
Depression for Primary Care Clinicians: New Developments in 1984

This course is designed to provide primary care clinicians with an overview of the evaluation, diagnosis, laboratory testing and clinical treatment of patients with depression. A lecture format with case presentations will be emphasized.

Michael Kobernick, MD
Management of Office Emergencies

This course is a practical guide to the management of common office emergencies. The curriculum includes discussion of pathophysiology and treatment of chest pain, dyspnea, syncope, anaphylaxis, shock, seizures and behavioral emergencies.

Robert S. Rhodes, MD, MPH
Occupational Health Concerns: Update 1984

This course is directed to all practicing physicians. It will provide practical information about occupational related health hazards commonly encountered by employees in the hospital and outpatient environment.

Neil S. Talon, MD
Psychiatric Aspects of Medical Practice

This course is designed to give general office and hospital medical practitioners a good background in common psychiatric problems seen in their patients.

Leonard F. Bender, MD
Strokes: New Help, New Hope

This course will introduce primary and consulting physicians to an interdisciplinary model of stroke care that has significantly reduced morbidity and mortality in a rehabilitation hospital setting.

Gilbert H. Mayor, MD
Use, Abuse and Interpretation of Renal Assessment Tests

These lectures are designed for non-nephrologists who nevertheless need a precise working

Ditmars

Fleischmann

Freitas

Goldstein

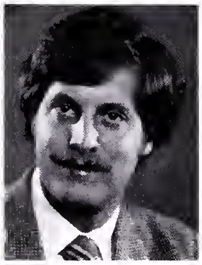
Gossain

Green

Honet

Jain

Klein


Kemink

Kim

Kobernick

knowledge of traditional, current and evolving methods of assessing renal structure and function.

Tuesday Afternoon November 13

Dale C. Blum, MD and Paul A. Berlin, BS, A-EMT
Advanced Cardiac Life Support Recertification

This recertification course is intended for those physicians already ACLS certified whose certifications are near expiration, or have expired no more than sixty days prior to November 13, 1984. A requirement for this course is proof of current BCLS certification. (A BCLS course will be offered the morning of the 13th.)

Antal E. Solyom, MD
Attachment Disorders in Infancy

The objective of this course is to provide an up-to-date overview of the conceptual and practical (diagnostic) aspects of early disorders of infant-parent relationships.

Phillip M. Green, MD
Elder Care Management: Changing Needs and Resources

This course, through presentations of the changing needs and resources in the State of Michigan, will enhance the appreciation of the particular difficulties involved in managing the impaired elderly patient.

Gaylord D. Alexander, MD
Everything You Wanted To Know About Local Anesthetics

The course will address the problem of which local anesthetic should be used in varying situations based upon each drug's unique pharmacologic properties. The problem of "allergies" to local anesthetic drugs will be discussed along with toxic reactions and their treatment.

John A. Penner, MD
Hematology

This course will present new information for primary care physicians as well as other specialists on topics such as thrombosis in the young adult, management of thrombocytopenia in the pregnant patient and office assessment of anemia.

Robert S. Ormond, MD
Modern Approach to Clinical Diagnostic Radiology

This course is designed to aid primary care physicians and radiologists in the efficient use of available radiologic modalities in clinical problem solving.

Raymond B. Bauer, MD
Neurological Problems of General Interest and Frequent Encounter

This course will provide primary and consulting physicians with the most recent information concerning four frequently encountered neurological problems.

Krishna M. Jain, MD
Non-Invasive Vascular Lab and the Primary Physician

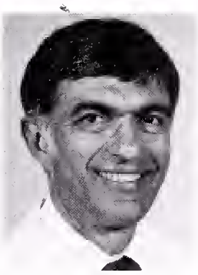
In recent years, great technological advances have been made in diagnosing vascular problems accurately and quickly with noninvasive techniques.

John J. LaFerla, MD
Tragic Events in Obstetrics and Gynecology: Coping With Bereavement and Infertility

Compared with other medical fields, obstetrics deals frequently with healthy patients. However, reproductive casualties (e.g., genital cancer, infertility, and

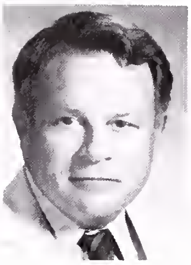
LaFerla

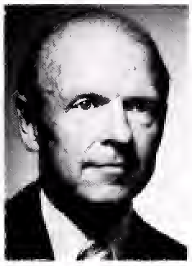
Lekas


Lucas

Mayor

Morrell


Murphy


Murray

O'Connor

Penner

Peppard

Perry

Rhodes

pregnancy loss) can result in profound grief and mourning. The object of this course is to present clinical approaches to helping patients and families cope with tragic events in obstetrics and gynecology.

Wednesday Morning November 14

Robert D. Allaben, MD
Alternatives in Management of Primary Breast Cancer

This course will emphasize alternatives to modified radical mastectomy in the treatment of primary breast carcinoma.

Joseph C. Honet, MD
Arm Pain and Dysfunction: Diagnosis and Management

This course, through actual patient presentation and demonstration using video camera enhancement, multidisciplinary panel reaction and discussion, will review and demonstrate the diagnosis, mechanics and treatment of some of the causes of arm pain and dysfunction.

Gunter Deppe, MD and Joan Stryker, MD
Carcinoma of the Female Reproductive Tract

This course will provide an update of information in the diagnosis of gynecologic malignancies pertinent to the clinical practice of the primary community physician.

Lyle D. Victor, MD, and Nicholas Lekas, MD
Chest Roentgenography for the Clinician

This course will provide practical information on chest roentgenography with an emphasis on the critically ill patient.

George L. Royer, Jr., MD
Current Update on the Use of Drug Monitoring as It Relates to Clinical Medicine

Improper drug dosing can lead to excess toxicity or lack of effectiveness. In this course, we will discuss the pharmacokinetics, drug distribution and half-life as it relates to drug levels.

Neil A. Swanson, MD
Dermatology in Practice

This course is designed to give the practitioner up-to-date knowledge of cutaneous signs of diseases which they commonly see in practice.

Sean B. Peppard, MD
Evaluation and Treatment of the Dizzy Patient

This course is designed to present the practitioner with a rational scheme for working up and managing the dizzy patient.

Larry E. Fleischmann, MD
Follow-Up of High Risk Infants: The State of The Art

The objective of this course is to present an overview of the need for follow-up of high risk infants and the mechanism by which this can be achieved. The state of the art of the follow-up of high risk infants will be presented.

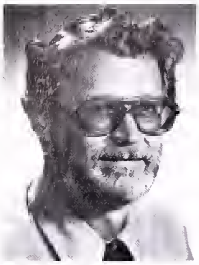
Charles P. Lucas, MD
Hypertension: Non-Pharmacological Treatment

This course will provide practical information as well as technical information to primary care physicians on the various non-pharmacological modalities available to treat high blood pressure.

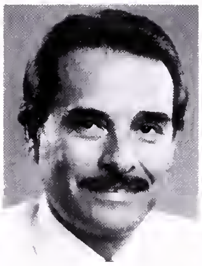
Wednesday Afternoon November 14

Roger M. Morrell, MD, PhD
Alzheimer's Disease: Pathogenesis, Diagnosis and Management

Alzheimer's disease and related disorders will be described for primary care and consulting physicians. Current concepts of pathogenesis, diagnosis and management will be reviewed.


Royer

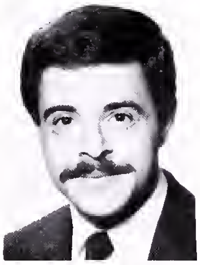
Saper


Solyom

Sosin

Stryker

Swanson


Talon

Thomas

Victor

Weiss

White

George A. Dean, MD
Clinical Nutrition

This course, through lectures and case presentations, will instruct primary care physicians and consulting physicians in the relationship between nutrition and the pathogenesis of chronic diseases.

John L. Kemink, MD
Common Laryngeal Diseases in Children and Adults

Michigan Otolaryngologic Society is pleased to present an afternoon relating the current diagnosis and management of common laryngeal and upper airway problems in children and adults.

Allen Sosin, MD
Controversies in Allergy

This course will present the practicing physician with an understanding of how to classify allergic problems; to recognize the effective methods of diagnosis and treatment of asthma and other allergic disease; and how to evaluate the proper use of medication.

Ved V. Gossain, MD
Diabetes Update: 1984

This course will review, for primary care physicians, the newer classification and criteria for diagnosis of diabetes mellitus (National Diabetes Data Group).

Howard A. Dean, DO
Diarrhea: A Diagnostic Dilemma

This course will present a multifactorial approach to the symptoms of diarrhea clinically from various aspects of possible etiology: infectious, inflammatory, functional and motor disturbance.

Gary W. Goldstein, MD
Epilepsy in Children

Using both lectures and demonstrations, this course will review recent advances in the diagnosis and treatment of childhood epilepsy.

Henry H. Sprague, MD
Examination and Treatment of Non-Operative Office and Sports Problems of the Upper Extremity

The objective of this course is to teach a thorough examination of the shoulder, elbow, wrist and hand to help physicians make common diagnosis from degenerative or injury sources and to indicate treatment approaches, their benefits and risks.

Miles J. Murphy, MD
Prenatal Care, Labor and Delivery: What's New in 1984

The purpose of this course will be to instruct and update family physicians and obstetricians in obstetrical care in 1984.

Neil A. Swanson, MD
What's New in Dermatology

This course is designed to give the dermatologist and practitioner up-to-date knowledge of new treatments and therapies to expect on the horizon. Exciting new mechanisms will be discussed.

Thursday Morning November 15

Raymond H. Murray, MD
Cholesterol and Coronary Artery Disease

This course is intended to update the primary care physician on the latest information regarding the relationship between blood lipids and coronary artery disease.

George L. Royer, Jr., MD
Clinical Update on Panic Disorders

In this course, the pathophysiology of panic disorders will be discussed. Attention will be given to how these mask common medical problems such as pulmonary and cardiovascular disease. New methods of treatment will be presented.

Joel R. Saper, MD
Current Management Strategies for Headache Disorders

This course is directed at the primary physician and will provide a practical review on current concepts in mechanism and treatment strategies for recurring headaches.

L. Murray Thomas, MD
Management of Low Back Pain

This course is designed to discuss state of the art methods for diagnosis and treatment of low back pain with specific reference to disorders of the intervertebral disc clinical presentation and pathophysiology.

Frederick W. Bryant, MD
Saving Sight: Recognition and Remedies

This course, which is designed for the non-ophthalmologist, will offer clues in the detection of sight-threatening situations and will also suggest effective treatments.

Joseph J. Weiss, MD
Topics in Rheumatology

This course will focus on three aspects of rheumatology important to the general physician: First, the technique and indications for joint aspiration; second, the office management of musculoskeletal complaints; and third, the diagnosis and treatment of shoulder pain and immobility.

Donald M. Ditmars, Jr., MD
Trauma: Pathophysiological Basis of Acute Care, Reconstruction and Research

This course will present new concepts in the control of wound-healing which will be applied to the everyday care of problem wounds.

Donald M. Ditmars, Jr., MD
Breast Reconstruction: 1984

This course will present a review of current techniques of breast reconstruction, including patient selection, timing of procedures and treatment of the opposite breast.

Jerry C. Rosenberg, MD, PhD
Clinical Organ Transplantation in the Eighties

This course will emphasize the clinical application of renal, hepatic, pancreatic, cardiac and bone marrow transplantation and the tremendous advances since cyclosporine was introduced.

Steven N. Klein, MD
Colonic Surveillance

This course will present an overview of the various modalities utilized in colonic surveillance. The physician will hear discussion with regards to radiologic, endoscopic, and mass screening techniques.

C. B. Dhabuwala, MD
Current Aspects of Male Infertility and Impotence

This course is intended for primary care physicians, urologists, and gynecologists dealing with infertility. Lectures and case presentations are intended to provide the practicing physician with a general approach toward investigations, diagnosis, and treatment of male infertility.

Luke Y. Kim, MD
Diagnosis and Management of Peripheral Nerve Disorders

This course will provide primary physicians with information that will enable them to appropriately perform clinical examinations, utilize diagnostic tests and develop a treatment plan for the patients with peripheral nerve disorders.

Jerome V. Ciullo, MD
Initial Management of Sports Injuries

The objective of this course will be to familiarize treating physicians with classification of soft tissue injury, initial management (including on-field care), and to help them recognize when to refer patients.

Howard A. Brody, MD
Medical Ethics and Malpractice: Is It Better to be Safe or Right?

Does being "legally safe" mean not practicing "good" medicine? If law and ethics conflict, what is the physician's obligation? What is a physician's obligation to compensate for an iatrogenic injury?

John E. Freitas, MD
Nuclear Medicine Update: 1984

This course will provide the primary physician with basic information on nuclear medicine procedures in three areas: nuclear cardiology, thyroid disease, and infection.

Thursday Afternoon November 15

Patricia A. O'Connor, MD
Behavioral Pediatrics

This course will provide practical information for primary care physicians and pediatricians about selected learning and behavior problems in children.

Win free room and dinner for two!

Win a complimentary room for two nights and dinner for two during your Annual Scientific Meeting stay. All you have to do is make your room reservations early!

To be eligible, simply make your reservation prior to October 18 for the October 22 drawing. Room reservations must be made *direct* with the Hyatt Regency Dearborn; 1800 Michigan Avenue; Reservations Office; Fairlane Town Center; Dearborn, MI 48126. The telephone number of the hotel is (313) 593-1234. Indicate that you are attending the MSMS Annual Scientific Meeting to take advantage of the convention rate. You could win a free room for two nights and dinner at the exciting Giulio and Sons restaurant in the hotel.

After October 18, rooms are on an availability basis only.

Plan to visit these firms' exhibits

There are 70 reasons why MSMS members will want to visit the exhibit hall during the MSMS Annual Scientific Meeting Nov. 13-15 at the Hyatt Regency Dearborn.

The trained professional representatives of 70 firms will be awaiting the opportunity to discuss with physicians the details of their products and services in a relaxed atmosphere.

The exhibit hall is an important part of the Annual Scientific Meeting, and is the site of registration for all courses and special events. In addition, the deli luncheons offered by MSMS to all Annual Scientific Meeting participants, and the Clinical Poster Presentations will be in the exhibit area.

To help MSMS members plan, exhibitors are listed below by category. Further information is available from Linda Munson at MSMS headquarters.

Pharmaceuticals

Ayerst Laboratories
Boehringer Ingelheim, Ltd.
Glaxo, Inc.
Hoechst-Roussel Pharmaceuticals
Knoll Pharmaceutical
Merck Sharp & Dohme
Merrell Dow Pharmaceuticals
Reed & Carnrick
Ross Laboratories
Searle Laboratories
Smith Kline and French Labs
Syntex Laboratories, Inc.
The Upjohn Company
Wyeth Laboratories

Clinical Laboratories

Advance Medical & Research
Allied Integrated Diagnostic Services
Dearborn Clinical Laboratory
Oakland Diagnostic Laboratory
Smith Kline Clinical Laboratories

In-Office Equipment and Support

City X-Ray Company
Cryomedics, Inc.
Firestone X-Ray Corporation
Metropolitan X-Ray Sales, Inc.
Michigan Bell
White & White, Inc.

Patient Home Care

American Orthopedic Service
Coreco Research Corporation
Support Systems International, Inc.
Upjohn Healthcare Services

Computers/Computer Services

ARGENT
Automated Business Consultants
Bennethum Computer Systems
CRT Management Company
Comedco, Inc. — P.A.S.S.
Data-Med Corporation
Diversified Technologies Automated Input
Diversitec
Tom Herbst & Associates
Macatawa Professional Systems
MEDIC Computer Systems
Medical Administrative Computer Service
Medical Billing Service
Medpac/Computer Method Corporation
Physician Service Group, Inc.
Professional-On-Line Computer
Rollins Medical/Dental Systems
Safeguard Business Systems
Vanguard Medical Equipment, Inc.

Educational Resources

T.R. Baxter & Associates
Encyclopaedia Britannica, U.S.A.
Health Professional Sales Group
J.B. Lippincott Company
W.B. Saunders Company

Protection

Blue Cross Blue Shield
First Heritage Corporation
John Hancock Companies
The Medical Protective Company
Michigan Physicians Mutual Liability Company
Physicians Insurance Company of Michigan
Stratton-Cheeseman & Associates, Inc.

Career Alternatives

Navy Recruiting-District Michigan
U.S. Army Medical Department

Other Exhibitors

Beacon Rehabilitation Services
Hack Shoe Company
International Cryogenics, Inc.
Medical Care, Inc.
Merrill Lynch
Michigan Ophthalmological Society
Professional Practice Sales, Inc.

Visit ASM poster presentations

When you're at the 1984 MSMS Annual Scientific Meeting, take advantage of a new feature being presented for the first time this year by the MSMS ASM Planning Committee.

Stop in at the Great Lakes Exhibit Hall at the Hyatt Regency Dearborn from 4:30 to 6 p.m. Wednesday, and visit the first-ever MSMS scientific poster presentations. Sixteen of the educational exhibits will be presented at that time by Michigan physicians who will be on hand to answer questions and explain their presentations in detail.

While you are browsing and learning from your colleagues' presentations, you will have the opportunity to sip wine and sample cheeses at a reception planned to accompany the poster presentations.

ASM Chairman David Rovner, MD, East Lansing, and his committee have been pleasantly surprised at the "enormously greater response" than they anticipated to their invitation to make poster presentations.

A total of 41 proposals for the presentations were submitted to the committee, he reports. "We reluctantly had to choose from among the many high quality abstracts submitted."

"We were most gratified at the big response and the high quality of the proposals. We invite all physicians attending the Annual Scientific Meeting to view the poster presentations and chat with their creators."

PLEASE SEND ENTIRE PAGE WITH CHECK

1984 MSMS Annual Scientific Meeting, Hyatt Regency Dearborn Registration form for Category I CME Courses

***All courses are approved for AAFP Prescribed Credit *EXCEPT* those marked with an asterisk.**

TUESDAY MORNING, NOV. 13

(8:30 to Noon, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Basic Cardiac Life Support
____ Brain Ischemia: Injury and Therapy
____ Conservative Management of Early Breast Cancer
____ Depression for Primary Care Clinicians: New Developments in 1984
____ Management of Office Emergencies
____ Occupational Health Concerns: Update 1984
____ Psychiatric Aspects of Medical Practice
____ Strokes: New Help, New Hope
____ Use, Abuse and Interpretation of Renal Assessment Tests

TUESDAY AFTERNOON, NOV. 13

(1:30 to 5:00, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Advanced Cardiac Life Support Recertification
____ Attachment Disorders In Infancy
____ Elder Care Management: Changing Needs and Resources
____ Everything You Wanted to Know About Local Anesthetics
____ Hematology
____ Modern Approach to Clinical Diagnostic Radiology
____ Neurological Problems of General Interest and Frequent Encounter
____ Non-Invasive Vascular Lab and the Primary Physician
____ Tragic Events in Obstetrics and Gynecology: Coping with Bereavement and Infertility

WEDNESDAY MORNING, NOV. 14

(8:30 to Noon, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Alternatives in Management of Primary Breast Cancer
____ Arm Pain and Dysfunction: Diagnosis and Management
____ Basic Cardiac Life Support
____ Carcinoma of the Female Reproductive Tract
____ Chest Roentgenography for the Clinician
____ Current Update on the Use of Drug Level Monitoring as it Relates to Clinical Medical Practice
____ Dermatology in Practice
____ Evaluation and Treatment of the Dizzy Patient
* ____ Follow-up of High Risk Infants: The State of the Art
____ Hypertension: Non-Pharmacological Treatment

WEDNESDAY AFTERNOON, NOV. 14

(1:30 to 5:00, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Alzheimer's Disease, Pathogenesis, Diagnosis and Management
____ Clinical Nutrition
____ Common Laryngeal Diseases in Children and Adults
____ Controversies in Allergy
____ Diabetes Update: 1984
____ Diarrhea: A Diagnostic Dilemma
____ Epilepsy in Children
____ Examination and Treatment of Non-Operative Office and Sports Problems of the Upper Extremity
____ Prenatal Care, Labor and Delivery: What's New in 1984
* ____ What's New in Dermatology

THURSDAY MORNING, NOV. 15

(8:30 to Noon, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Basic Cardiac Life Support
____ Cholesterol and Coronary Artery Disease
____ Clinical Update on Panic Disorders
____ Current Management Strategies for Headache Disorders
____ Management of Low Back Pain
____ Saving Sight: Recognition and Remedies
____ Topics in Rheumatology
____ Trauma: Pathophysiological Basis of Acute Care, Reconstruction and Research

THURSDAY AFTERNOON, NOV. 15

(1:30 to 5:00, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Behavioral Pediatrics
* ____ Breast Reconstruction: 1984
* ____ Clinical Organ Transplantation in the Eighties
____ Colonic Surveillance
____ Current Aspects of Male Infertility and Impotence
____ Diagnosis and Management of Peripheral Nerve Disorders
____ Initial Management of Sports Injuries
____ Medical Ethics and Malpractice: Is it Better to be Safe or Right?
____ Nuclear Medicine Update: 1984

The MSMS Committee on CME Programming, an organization accredited by the MSMS Committee on CME Accreditation, certifies that this activity meets the criteria for a maximum of 18 credit hours in Category I toward the requirements for Michigan relicensure and of the Physician Recognition Award of the AMA, provided it is completed as designed.

Please check the courses you wish to attend. In each case, please indicate a second choice should the first choice already be filled. Maximum attendance figures have been set for each course, depending on room size.

Send this entire page with your check. Confirmation of your reservation will be sent to you. Your course credentials, badge, and luncheon tickets must be picked up at the MSMS Registration Desk in the Great Lakes Exhibit Center.

Physicians must make their own hotel reservations prior to 10/18/84 direct with the Hyatt Regency Dearborn, Fairlane Town Center, Dearborn, MI 48126, 313/593-1234. In order to take advantage of the special conference rates, please mention that you will be attending the MSMS Annual Scientific Meeting.

See room reservation card for details about how you can win a complimentary room and dinner for two at Giulio's by making your room reservations early!

Name (please print) ______________ (first) ______________ (initial) ______________ (last)

Street ____________________________________

City, State ______________ Zip ______________ Phone ______________

MSMS Member: Yes ____ No ____ Resident ____ Specialty ______________ Other ______________

Tuition Schedule for Courses:

MSMS members: $6 per credit hour, or $18 for each half-day course
MSMS members with "retired status" pay half the regular course fee
Non-members: $12 per credit hour, or $36 for each half-day course
Residents: $5 PER COURSE (Does Not Include Lunch)

A deli sandwich lunch will be provided at no extra charge. Advance notice is requested so MSMS can give an accurate guarantee. Please indicate which days you want a lunch ticket.

- Tuesday lunch ______ Wednesday lunch ______ Thursday lunch ______
- Indicate total number of half-day courses: ____ x $18 (members) $ ______
  ____ x $ 9 (retired) $ ______
  ____ x $36 (non-members) $ ______
  ____ x $ 5 (residents) $ ______
- Please enroll me in the MSMS/PSG seminar, being held from 7-9 p.m. (Physicians' guests are free.) Tue. 11/13 "Personal Financial Planning and Tax Advantaged Investing" ____ x ($18 fee) $ ______

TOTAL $ ______

Make checks payable to MSMS and mail to MSMS, Box 950, East Lansing, MI 48823.

Angina Protection with Benefits for a Lifetime

ONCE-DAILY CONTROL WITH HEART-SAVING BENEFITS

By reducing heart rate and cardiac contractility, INDERAL LA helps protect the heart from the potentially serious and debilitating consequences of ischemia. A highly effective antianginal agent for around-the-clock control of symptoms, INDERAL LA also provides cardiovascular protection for a sense of security in the years ahead.

PROTECTION AND EXPERIENCE NO CALCIUM BLOCKER CAN MATCH

Unlike calcium blockers, INDERAL LA—either alone or with a nitrate—is recommended for early treatment of angina in the majority of patients. Equally important, INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use.

START WITH 80 MG ONCE DAILY

Dosage may be increased to 160 mg once daily, as needed, to achieve optimal control. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY **INDERAL LA**

(PROPRANOLOL HCl) LONG ACTING CAPSULES

80 mg
120 mg
160 mg

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories

Ayerst

JUST ONCE EACH DAY FOR SIMPLIFIED CORE THERAPY IN ANGINA

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES

®*

80 mg 120 mg 160 mg

Just once each day...

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

> IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

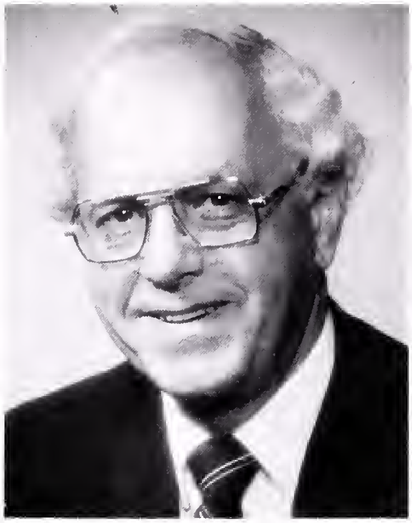
*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

8833/384

Ayerst.

AYERST LABORATORIES
New York, N.Y. 10017

Tryloff



Ambrose

Madigan

Warren Tryloff steps down

MSMS Executive Director since 1970, Warren F. Tryloff, has stepped down from active duty with the medical society. He will officially retire July 31, 1985, upon completion of 31 years of service to the organization.

On September 1, Mr. Tryloff turned over his present staff duties to a new leadership team. Until his retirement, he will serve as consultant to the MSMS Board of Directors, and will be completing several projects.

In the new organization Bruce W. Ambrose, a 14-year MSMS veteran, will take over as executive director, while William E. Madigan, who has been with the staff for 10 years will serve as managing director.

Mr. Tryloff serves as executive vice president of the MSMS Physician Service Group, Inc., and as vice president of the Michigan Foundation for Medical and Health Education. He is past president of the Professional Convention Management Association and is a member of the American and European Society of Association Executives.

A long-time resident of East Lansing, Mr. Tryloff and his wife, Nancy, and their youngest daughter, Maggie, will reside in Hamilton, Ohio.

Mr. Ambrose's new responsibilities include subsidiary company operations as well as executive duties in MSMS. Mr. Madigan is responsible for the management of the medical society and will oversee general operations.

MSMS leaders pay tribute

Dear Warren:

My, how time does fly! It seems like just yesterday that we were neophytes beginning our experience in organized medicine.

I take great pride in having been a member of the search committee that recommended you for the position of executive director of MSMS. You have exceeded our greatest expectations! Your quiet, firm, and knowledgeable direction has helped make MSMS an outstanding medical organization, second to none.

Your uncanny ability to select and develop an outstanding staff is admired and appreciated by all physicians of Michigan. Your leadership, dedication, and responsibility have been contagious, as evidenced by the functioning of your excellent staff. We all have been constantly amazed at the dedication that you and your staff have to the members of MSMS and to their delivery of quality medical care to our patients. Your sincere and honest guidance has been a real asset to our patients and to the physicians of Michigan.

Michigan medicine and all that it represents will miss you! However, I know that you have planned, in your usual capable fashion, the future of MSMS. We are all positive that because of your leadership, the staff of MSMS will fullfill our expectations.

I personally would like to thank you ever so sincerely for your guidance and cooperation, your friendship to Dorie and me, and for your untiring, selfless devotion to MSMS. Dorie and I wish you and Nancy the happiest, longest, and most confortable retirement. If at any time I can be of any help to you, you know where I am.

MSMS will miss you! We all will miss you!

Respectfully,
John H. Coury, MD
Chairman, AMA Board

Coury

Zako

Berglund

Mandell

Leitch

Johnson

The retirement of Warren Tryloff as director of the Michigan State Medical Society marks the end of a magnificent era. Over the decades, Warren has served MSMS and the physicians of Michigan with unparalleled grace, dignity, and excellence. He has demonstrated superb managerial and administrative skills, sensitivity and unique understanding of the peculiar personality of physicians, and keen insight into the really important issues of the day.

The excellence of the MSMS staff is largely attributable to Warren's ability to attract and advance men and women of high ability. The love and loyalty of his staff is a tribute to his warmth and humanity, as much as it is to his managerial skills.

Under Warren's leadership, MSMS has become one of the most effective and respected professional associations, not only in Michigan but throughout the nation. While not universally successful, MSMS has come to grips with a host of difficult issues: physician competition, hospital-medical staff relationships, third party problems, malpractice, etc.

The creation of MPMLC, of PSG, of PROM, as well as the establishment of a variety of physician support efforts (PSRO Support Center, Bureau of Economic Information, et al) are among Warren's accomplishments in responding to the challenges of the 50s, the 60s, the 70s and the 80s. With the recent adoption of the MSMS strategic plan by the Board of Directors, Warren has left his successors, Bruce Ambrose and Bill Madigan, with a blue-print for continuing this tradition of meeting the challenges of the times.

It has been my personal privilege to have worked with Warren Tryloff in a variety of capacities for almost a decade and a half. He has taught me much during that relationship. Each and every one of us is touched by the retirement of this man. I personally shall deeply miss his counsel and his friendship.

Louis R. Zako, MD
MSMS President

Warren Tryloff is a unique person!! During my years of activity in MSMS I have marvelled at Warren's leadership style. During the past years as vice chairman and chairman of the Board of Directors I have had the opportunity and distinct pleasure to work with Warren on a daily basis in the management of MSMS.

The director of MSMS, our chief staff executive officer, and the chairman of the Board of Directors develop a close relationship in the day-to-day management of our medical society. Warren and I have not only developed this closeness, but have become good friends in the process.

During his 30 plus years at MSMS, Warren always has had a commitment to MSMS. He is a loyal employee, always keeping the good of MSMS uppermost in his mind. He has been extremely well organized, a motivator of people, one who can delegate and still maintain a sense of the mission. He is thoughtful, receptive of other's ideas, and always resourceful. Warren is and has been a gentleman and as complete and perfect an executive as we could hope to have.

Warren, I personally will miss working with you. I wish you and Nancy well in your retirement. I hope we will be able to call upon your vast experience and knowledge as we go through our transition of leadership. Thank you for giving us 30 plus years of yourself!!

Thomas R. Berglund, MD
Chairman, MSMS Board

Dear Warren:

It is difficult for me to accept the idea that you are retiring from your position as executive director of our beloved MSMS.

continued on page 442

Competence counts

Hurley Medical Center photo

In selecting a doctor, 74 percent of Americans consider competence, not cost.

Competent doctors remain the key to health. But competence isn't immunity to litigation.

Consider our competence – and our professional liability protection and strong-defense philosophy.

We defend you against non-meritorious claims. We won't settle a claim without your approval or merely to cut our defense cost.

PICOM
Physicians Insurance Company Of Michigan
4277 Okemos Rd., Box 1000
Okemos, Michigan 48864
(517) 349-6500
(313) 557-4845
1-800-292-1036

I have asked myself why you are retiring in your very prime, but I haven't reached any solid conclusion.

Perhaps you think that you are older than you are. Never! Perhaps you think that your staff will survive without you. Who knows?! You may even think that you no longer look dapper and trim. Impossible! You may think that you have lost your gentlemanly and yet firm demeanor. Unimaginable! You may think that it is time to step aside to allow a new infusion of exuberance, confidence and dedication. (It is always nice to be around exuberant, confident and dedicated people.)

In my years of getting to know you, you have displayed the personal traits and leadership characterized above. Indeed, despite your responsibilities, you have maintained optimism, serenity, charm and a continental grace.

Those of us who are privileged to know you have gained from your experience and poise. You have built a strong, effective organization to continue our goals, but we, of MSMS, will find it difficult to replace you as a leader. In our hearts you cannot be replaced.

For our membership and myself, we salute you and wish you well in your retirement.

Gerald H. Mandell, MD
Speaker, MSMS House
of Delegates

The impending departure of Warren Tryloff from the MSMS staff will create a void which will be impossible to fill. For many years, his name has been synonymous with all that is good and effective with organized medicine in the state of Michigan.

The state medical society has grown markedly in membership and staff activity during Warren's tenure. More importantly, however, the scope and effectiveness of the services provided by the society to the physicians in Michigan have increased exponentially. Warren's management skills have been patently apparent in the activities of MSMS over these years.

I will feel a deep sense of personal loss with Warren's departure. Warren was a young, new member of the MSMS staff at the time I first became involved in medical society activities. It has been interesting to see how his career developed over the years and with it the scope of activity of the society.

He became director shortly after I became a councilor, and his effectiveness in that position was almost immediately apparent. The many hours we spent together in planning activities during my years as council chairman and later as president were invaluble to me as well as to the medical society in general.

Warren was probably the most effective force in the organization and early development of Michigan Physicians Mutual Liability Company which MSMS organized during the "malpractice crisis" of the mid-1970s. His wisdom and foresight have served the company well as it has continued to grow and flourish, providing professional liability insurance for ever larger numbers of MSMS members.

Warren Tryloff will be irreplaceable as director of MSMS, but he surely has provided a standard which can be aspired to by his successors. Their jobs should be easier because of Warren's foresight and training.

We hate to see you go, Warren, but we wish you godspeed and good health and happiness to you and Nancy over many fruitful years of retirement. You have merited my personal heartfelt thanks, as well as the gratitude of all Michigan physicians.

Robert M. Leitch, MD
MSMS Secretary

My first reaction to the news of Warren's retirement was very mixed — happy, for him and Nancy in that something obviously planned for some years is becoming a reality; sad, that the physicians of Michigan, including myself, will no longer have the benefit of his intellect, his wisdom, his experience, and of course the chuckle that went with his smile. Nancy will be missed for her quiet good humor and outgoing personality.

As I'm limited to a prescribed number of words, I can touch only the surface of events which I regard as the most memorable. The first was the selection and acquisition of the site; followed by a review of several architectural plans; selection of Yamasaki as the architect, and the approval of his plans; the progress of the actual construction with several unforeseen difficulties occurring but eventually leading to completion of the MSMS building. There followed the selection of the furnishings, including the *long* table in the board room, the horse shoe nail sculpture, the framed oil painting, all these selected by Lillian Pierce.

Finally, the day of dedication, with many prominent guests and a large audience to celebrate this achievement.

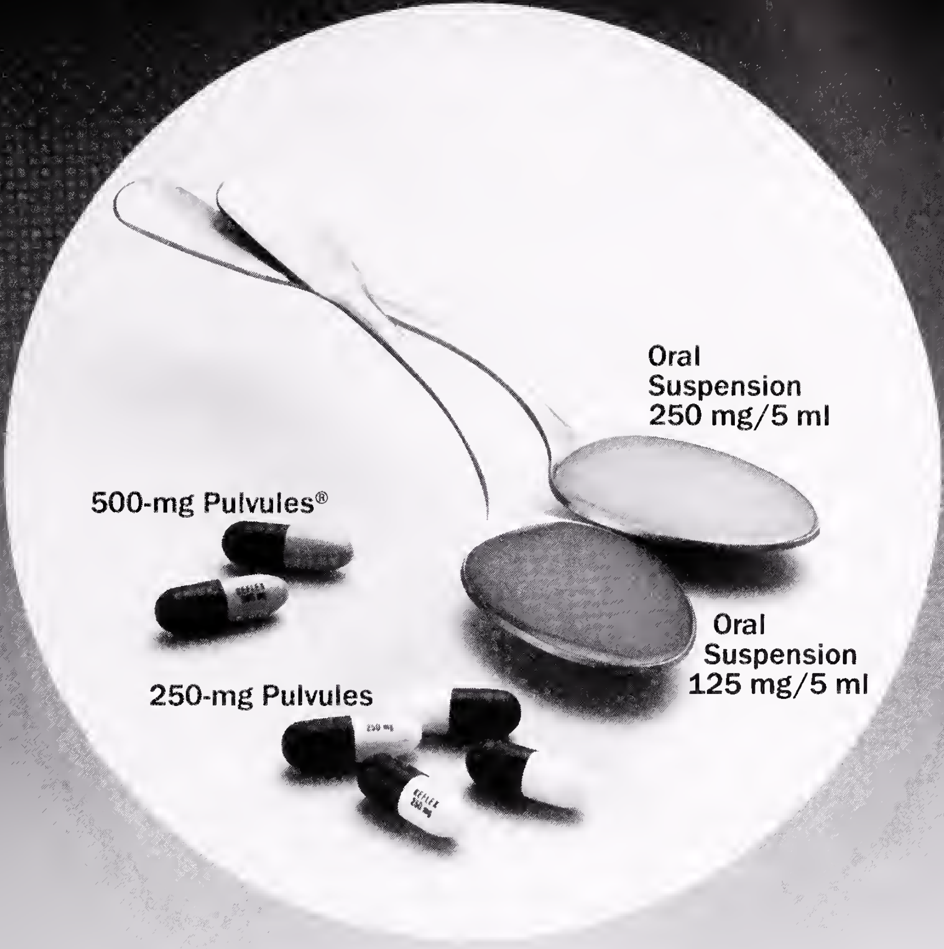
Throughout the course and progress of this monumental undertaking, Warren and I (as well as others) met many times, as we watched the vision of the architect become the reality of the headquarters of MSMS. It may be recalled that the original idea of this building was energetically opposed by some, accepted with lukewarm approbation by others and applauded by the great majority *only* after it was a "fait accompli."

Sorry, Warren, but you can't take the building with you.

As I close this tribute, I believe my contact with the physicians of Michigan, gained through many years of involvement with MSMS as speaker, president, and secretary, provides me with a special privilege to speak for all of us in wishing you, Warren and Nancy, success and happiness in your retirement.

Kenneth H. Johnson, MD
Former MSMS officer

Easy To Take


Oral
Suspension
250 mg/5 ml
500-mg Pulvules®
Oral
Suspension
125 mg/5 ml
250-mg Pulvules

Keflex®
cephalexin

Additional information
available to the profession
on request.

DISTA
420113

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

thoughtful. I was pleased to wear it.

Lou Zako was present for the inaugural ceremonies at the AMA House of Delegates and accompanied me to the reception honoring Billie Brady, AMA Auxiliary President for 1984-85.

I feel my background as registered parliamentarian should prove an asset in this new responsibility.

With sincere appreciation,
Betty Drew
1983-84 President
MSMS Auxiliary

I wish to express my appreciation to the Michigan State Medical Society for continued support of medical student involvement within MSMS. I have just returned from Chicago as the MSU College of Human Medicine delegate. While in Chicago, I had the pleasure to again meet and interact with members of the Michigan delegation. I was very pleased to see the support of most of the student initiated resolutions submitted through both the MSMS House of Delegates and the Medical Student Section. Our MSS resolutions met with great success in the AMA House of Delegates.

Our growing participation at MSU has hinged on the enthusiastic support within the Michigan State Medical Society. In the past year, I have seen our school involvement increase markedly, membership going up and an active role rising both at state and national conventions, and at the state committee level. We at MSU feel we are building the foundation of a healthy relationship between the rigors of medical education and the complexity of the medical profession, which organized medicine is trying to address.

I hope to continue my active participation within the Michigan State Medical Society with your helpful support.

Daniel R. Henley, CHM-2
Delegate
AMA Medical Student Section

Thank you for the pictures taken at the 1984 MSMS House of Delegates meeting in Grand Rapids. It was an honor to have you do the (50-year) presentations.

For the record, I also had my son take a picture of me with your current president, Louis Zako, MD. Both pictures are now framed and in a place of honor in my home.

The ceremony was a delightful idea, and was of profound emotional effect on all of the participants.

Max K. Newman, MD
Paradise Valley, AZ

The following open letter to all physicians is printed here on request.

Aid needed for Poland, El Salvador

We are making an urgent appeal to the members of your society to come to the aid of their fellow MDs with the "medical crumbs" of our wasteful state and nation.

We have received a request from the Polish American Congress for assistance with supplies needed in their hospitals in Poland. We can provide MSMS members with a detailed list of these needs.

Since 1982, we have made 21 shipments to Poland, with total weight of 455,596 pounds, and total value of $14,386,942.06. The needs in Poland are simply appalling; they even have to use their dressings over and over again, as new dressings simply are not available.

OBSTETRICIAN
SIGN IN HERE
RON MORGAN

"They're carrying this zero population growth business too far."

A director from another relief agency went to Poland to evaluate their needs. He came down with the flu, could not get an aspirin or cough medicine; he had to fly home with a 103° temperature. He told me: "Mrs. Auberlin, they can use anything, they just don't have any medical supplies." The Polish American Congress, through which we make all shipments, pays for all shipping costs. Shipments are sent to the Polish Episcopate for their distribution to the needy hospitals. Our supplies do not get into government hands.

Also, we have needs to be met to help the refugees in El Salvador. We are involved with the retired Air Commandos (they are doctors and medics, not military) who provide medical aid to the refugees. Four shipments of 41,969 pounds, value of $3,513,690 have been shipped, with more to go. The Commandos tell us this is a drop in a bucket. Conditions are appalling.

IV SOLUTION IS ONE OF THE ITEMS THAT IS DESPERATELY NEEDED. The Salvadorans even will take close-dated and outdated IV Solution. The doctors tell us the refugees are dying like flies in El Salvador. Doctors may contact their hospitals to obtain a change of brand or short dated IV solution to send us.

If doctors would just contact their hospitals and detail men for all types of medical suplies, vitamins, IV solutions, which are so urgently needed in Poland and El Salvador, they would be doing a great act of charity.

God love you for anything you can do.

Mrs. L. G. Auberlin
President
World Medical Relief
11745 Twelfth St.
Detroit 48206

P.S. — We have urgent need of tea bags for Poland, also hospitals have no aspirin or fruit juices. Please be generous. Contact Clubs & Churches. You can buy 100 A&P tagless tea bags for 79¢.

Who needs over a million dollars in professional liability protection?

Very Possibly YOU Do!

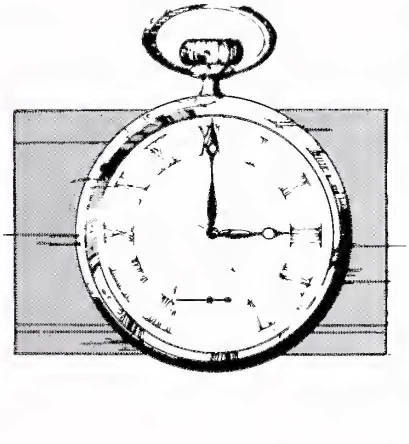
The Michigan lawyers' MILLION DOLLAR CLUB is comprised of attorneys who have won awards over that amount, many from physicians or surgeons who had exercised their very best judgement.

And the jury awards continue to grow.

The Michigan Doctor's Excess Professional Liability Insurance affords...

Protection That Starts When Your Present Policy Stops – And The Jury Keeps Going.

It does not replace your present policy, but it surely supplements it – up to $3 million additional limits.



Now Is The Time To Act!

Changes are effective right now that could be very beneficial to you and your practice. Such as:

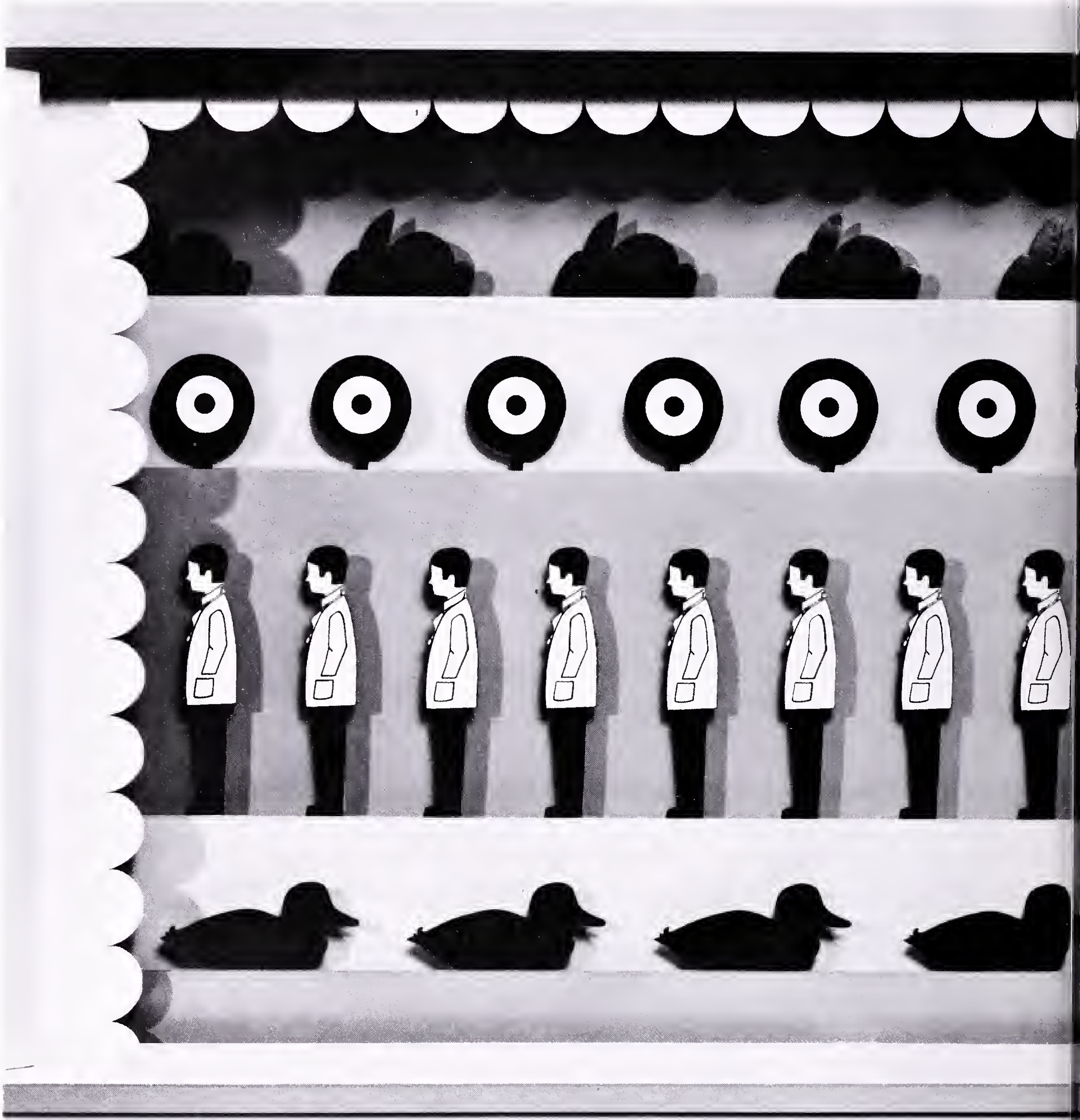
- The availability of limits of liability up to **$3,000,000/$3,000,000** excess of $200,000/$600,000 or excess of $1,000,000/$1,000,000;
- A **rate reduction of 10%** for all classes purchasing limits in excess of $200,000/$600,000;
- For P.C.'s, clinics, etc., **discounts up to 50%** for relief or substitute physicians;
- **40-30-30 payment plan** available for annual premiums of $5,000 and above.

For further details about Michigan Doctor's Excess Professional Liability Insurance, please contact HASCO or your insurance agent.

Underwritten by: **PACIFIC EMPLOYERS INSURANCE COMPANY**
Los Angeles, California

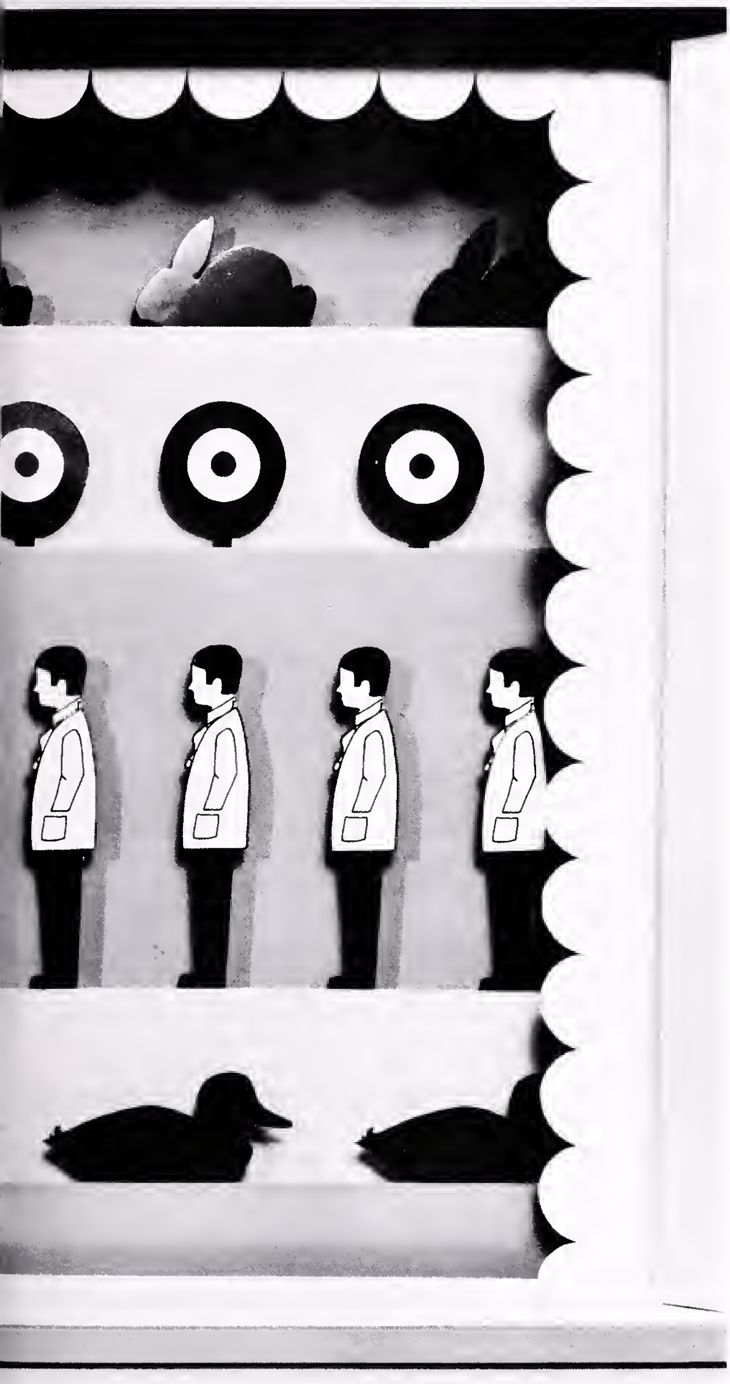
Serviced by:
HASCO
P.O. Box 33008
Detroit, Michigan 48232
(313) 567-1955

If you become the target of a



©1983 MPMLC

professional liability claim...



You will be glad you have Michigan Physicians.

Michigan Physicians has been solving complex medical professional liability problems since 1976. With the state's largest and most experienced claims staff, Michigan Physicians works with you to resolve claims (and incidents) that most physicians have never faced in their careers.

In a changing legal environment, you need the best coverage you can buy because the risk of a professional liability claim is becoming greater every day.

For a confidential rate quotation and more information about Michigan's leading physician-owned insurance company, call or write the office in your area.

Michigan Physicians
Mutual Liability Company

1305 Abbott Road
East Lansing, MI 48823
(517) 351-1150
(800) 292-1926

6735 Telegraph Road
Suite 205
Birmingham, MI 48010
(313) 647-5550

Endorsed by the Michigan State Medical Society

Watch for measles

By Evelyn Dykewicz, RN

Michigan has been experiencing a measles outbreak this year and currently leads the nation in the number of cases. There were 450 cases confirmed by the first week of August, whereas 45 cases were recorded for all of 1983.

Sources

Many of the measles cases were transmitted during school sporting events this past winter. Two hockey tournaments were held within a two week period in Port Huron with 40 teams participating. Students came from as far away as Alaska and Alabama and also from Ontario. This meet developed as a source of measles imported from Ontario.

Ann Arbor hosted a regional wrestling meet in January. A visiting coach developed measles two days after the meet; subsequently, several students came down with measles. During the same month there was a serologic confirmation of a single measles case in a dorm at the University of Michigan. A full scale outbreak control was initiated — 2,500 health records were screened and 4,500 were immunized.

In 1978 Michigan also ranked first in measles nationally with 8,000 cases. An intensive statewide immunization catch-up program was put into effect in 1979, as a result, Michigan experienced only 45 cases last year.

In the recent outbreaks, some students were immunization compromised, having had their vaccination before 16 months of age. The age span of those contracting the disease was from six months to 42 years, with a mean age of 11.2 years, and 13 the most reported age of persons with the illness. There were 10 cases in persons over the age of 28 years.

To assist the promotion of increased immunization levels in the state, Governor Blanchard declared August as Immunization Action Month. Some members of the Detroit Tigers provided public service announcements on radio and television to aid in this endeavor.

Action

Physicians should watch for local exposure and are urged to report suspected measles cases to their local health department. Acute and convalescent samples of venous blood should be sent to the local health department. The first blood sample should be obtained close to the onset of the rash and the second sample obtained one week later. The blood sample should have the patient's name, the date of rash onset, and the date each sample was collected. The Michigan Department of Public Health can test for measles antibodies with the IgM between one to three weeks after the rash onset.

The classification of reported measles cases by the Michigan Department of Public Health is as follows:

Suspect cases — rash and fever

Probable cases — rash of > three days, fever of > 101°F, cough coryza or conjunctivitis

Confirmed cases— serologic confirmation or a probable case which is epidemiologically linked to another confirmed or probable case.

Mrs. Dykewicz, of Flint, is Immunizations Project director for the MSMS Auxiliary.

Professional
INSTALLMENT LOANS
$15,000
TO
$90,000

Decision In
24 to 48 Hours!

Same-Day Answer to Applications Received By Express Mail

- Deal Directly With Lender
- Deferred Payment Plans
- No Prepayment Penalty
- No Restriction on Use of Funds For:
  Investments
  Payment of Taxes
  Debt Consolidation
  Tax Shelters
  Pension Plan Contributions

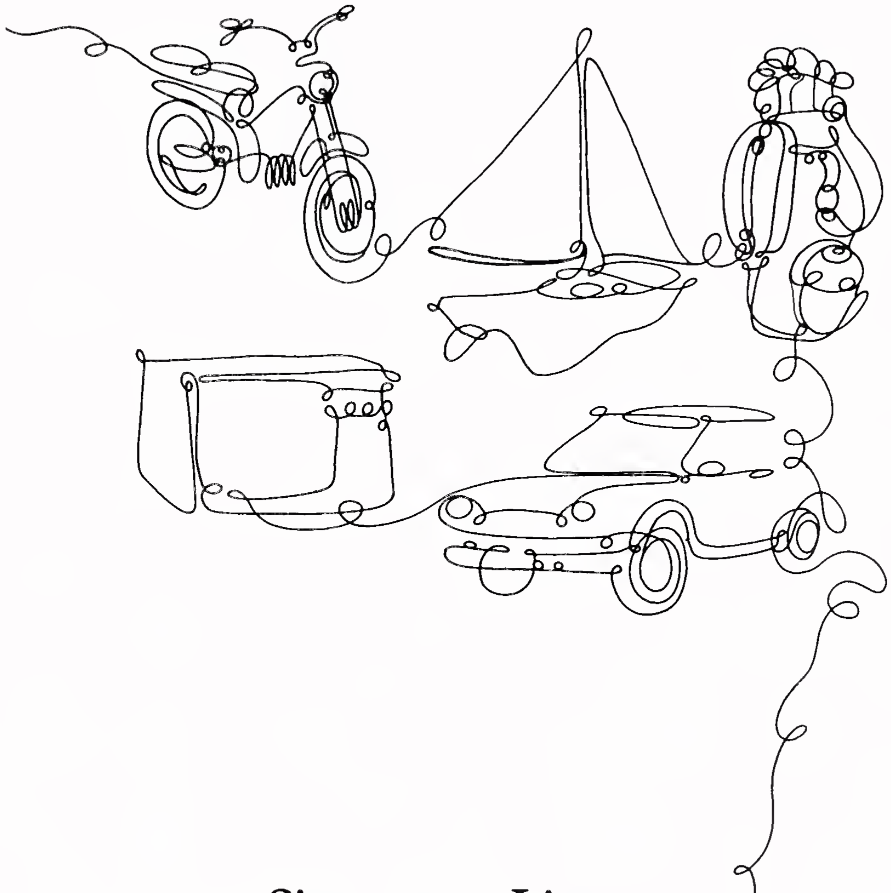
Ask for Tom Todd

CALL TOLL FREE:
800-423-5025

Serving The Medical Profession Since 1966

WOODSIDE CAPITAL CORP.
National Headquarters
Woodside Capital Building
21424 Ventura Boulevard
Woodland Hills, California 91364

The shortest distance between you and your credit needs:



Signature Line

We'll lay it on the line: you file one credit application. You draw from one line of credit. You use it for anything you want. You make one payment every month or every quarter. It's just what a person of your means needs—and deserves.

We'll lay our rate on the line, too: When your balance is $1,000 or more, you'll pay 2% above prime*. That's lower than most other forms of credit. And no matter how high the prime goes, you won't pay more than 18% APR.

Let's face it. You don't need the bother of completing an application every time you want credit. Don't. Choose the shortest distance between you and your credit needs: Signature Line.

Phone 1-800-632-4453 during normal business hours.

Call Union Bank, toll-free, for a Signature-Line brochure and application.

*Signature Line interest rates are based on Union Bank's prime rate. The Annual Percentage Rate may vary from 11.5% to 18% if your average daily balance is over $1,000. If your average daily balance is $1,000 or less, the Annual Percentage Rate (APR) is 18%.

UB UNION BANK
Member FDIC

200 Ottawa N.W./Grand Rapids, MI 49503-2468

the IMPACT of government and economics on medical practice today

Barrett **Howe**

Register today!

1984 MSMS Public Affairs/Leadership Conference Oct. 25

Here's a chance for MSMS, county medical society and specialty medical society leaders from around Michigan to hear top governmental, educational, public opinion and medical speakers.

It is the annual MSMS Public Affairs/Leadership Conference Oct. 25 at Long's Convention Center, Lansing. Speakers will include Attorney General Frank Kelley; political analyst Richard Scammon of Washington, DC; and no-fault medical liability insurance expert Jeffrey O'Connell, JD, of Charlottesville, VA.

Each of these leaders will bring the benefit of their perspectives and expertise to help Michigan physicians better understand the forces shaping medical care delivery today.

Make your plans now to attend this excellent "backgrounder" on the medical practice world. Check the complete program on this page, the biographical notes on the preceding page and then fill out the form below.

MSMS looks forward to seeing you on Oct. 25!

Who's on the program

Physicians, government officials, educators and pollsters all have differing perspectives on the major issues in health care delivery today.

State and local leaders of organized medicine need to know these perspectives and the people who hold them.

To that end, MSMS will present its 1984 Public Affairs/Leadership Conference, Oct. 25 at Long's Convention Center, Lansing.

Legislative and government leaders, expert educators and one of the nation's leading political analysts will share their insights with the MSMS, county medical and specialty society leaders who attend the conference.

Chairman of the conference is Fred E. Patterson, MD, Ann Arbor. He, his committee and staff have secured the following conference speakers:

Jeffrey O'Connell, JD, University of Virginia, who will discuss a proposed Michigan medical liability no-fault system. Professor O'Connell is the author of the Michigan Automobile No-Fault Insurance law.

Richard Scammon, head,

1984 Public Affairs Leadership Conference
Michigan State Medical Society
P.O. Box 950
East Lansing, Michigan 48823

For more information:
Please contact Sherry Wellman
at MSMS Headquarters —
517/337-1351

Please print or type.

Name ______________________

Address ______________________

____

Name ______________________

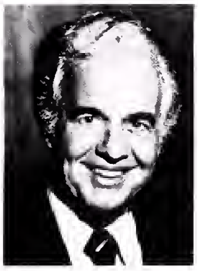
Address ______________________

Please check one

☐ Physician ☐ Other ________

Registration Fee: $35 for luncheon & "Challenge of the 80s" book
$15 — Students & Residents

Amount enclosed $ ________
Please make check payable to Michigan State Medical Society


Kelley

Kozlowski

O'Connell

Scammon

Elections Research Center, Washington, DC, political pollster and analyst of national reputation. Mr. Scammon is the popular lecturer of the 1980 MSMS Public Affairs/Leadership Conference, and will discuss the 1984 Presidential election. He is author of several volumes on American voting records and has served on a presidential statistical commission, the American Arbitration Association board, the National Council on Public Polls and the US delegation to the UN.

Frank Kelley, Michigan attorney general, who will keynote an afternoon forum on dealing effectively with incompetent physicians. With Attorney General Kelley in the forum will be the physician members of the Michigan Board of Medicine.

Mr. Kelley, a Detroit native, has served in his present post for 24 years. He created the Michigan Consumer Protection and Organized Crime divisions, and the Medicaid Fraud Unit. He has served as president of the National Association of Attorneys General.

James Barrett, president, Michigan State Chamber of Commerce. Mr. Barrett will present a business perspective on Michigan health care issues. He has been president and chief executive of the state chamber since 1976, and also heads its member services subsidiary. He is a member of the boards of the Michigan Economic Development Authority and the Michigan Chamber of Commerce Executives and is treasurer of the Michigan Business Political Action Committee.

Joseph Kozlowski, corporate manager of employee benefits planning for TRW, Inc., Cleveland. Mr. Kozlowski's topic will be "balancing the employee benefit package and health care costs." He is a member of the US Chamber of Commerce Health Care Committee. He serves on the advisory boards to the National Clearing House of Business Coalitions for Health Action and to the Health Research Institute. He has made presentations on health care costs before the National Blue Cross Blue Shield Association, the AMA Leadership Conference, the Washington Business Group on Health, the Health Insurance Association of America, and the California Hospital Association.

Elizabeth P. Howe, director, Michigan Department of Licensing and Regulation. Mrs. Howe will sit on an afternoon panel discussing how to deal effectively with medical licensure and discipline. Mrs. Howe has been department head since appointment by Gov. Blanchard in 1982, and has worked closely with MSMS leaders to strengthen and improve the Board of Medicine's functions. She was director of communications efforts for Gov. Blanchard's gubernatorial campaign, and previous to that was general manager of the United Nederlander Cable TV Company of Birmingham and public affairs and human resources executive for the Bendix Corporation.

Havenwyck Hospital*

- Inpatient Psychiatric Care
- Adult Program
- Adolescent Program
- Children's Program
- Day Hospitalization Program
- Neuropsychiatric Testing Service
- 24 Hour Emergency Admissions
- Voluntary and Involuntary Admissions
- JCAH Accredited

Mail To: **Havenwyck Hospital**
1525 University Dr.
Auburn Hills, Mich. 48057
313/373-9200

____ Newsletter
____ Information on Future Lectures/Seminars
____ Information on Havenwyck Hospital
____ Information on Speakers Bureau

Name ____________________
Firm ____________________
Address ____________________
City ____________ State ______ Zip ______
Telephone ( ) ____________________

* A division of Healthcare Services of America

YOU'RE NOT ONLY OUT

And you can be even farther out front with a tailor made financial planning instrument from Life of Virginia.

As a discerning professional, you give considerable thought to a variety of decisions that effect your financial security: flexibility, performance, and tax treatment to name just a few.

Now all of those elements are available in one package from the industry leader. Fundamentals such as:

Flexibility. Premium payments that can be increased or decreased or skipped altogether, depending on your needs.

Performance. Universal life products that credit current, competitive interest rates on cash values over $1000.*

Favorable tax treatment. Products that enjoy the tax preferences you get from any life insurance policy, as confirmed by the 1982 Tax Bill.

Adaptability. Coverage that can be adjusted up or down to meet changing needs, without adding new policies or canceling old ones.

Utility. Policies that offer such a wealth of possibilities that each comes with a Buyer's Manual to help you take full advantage of their features.

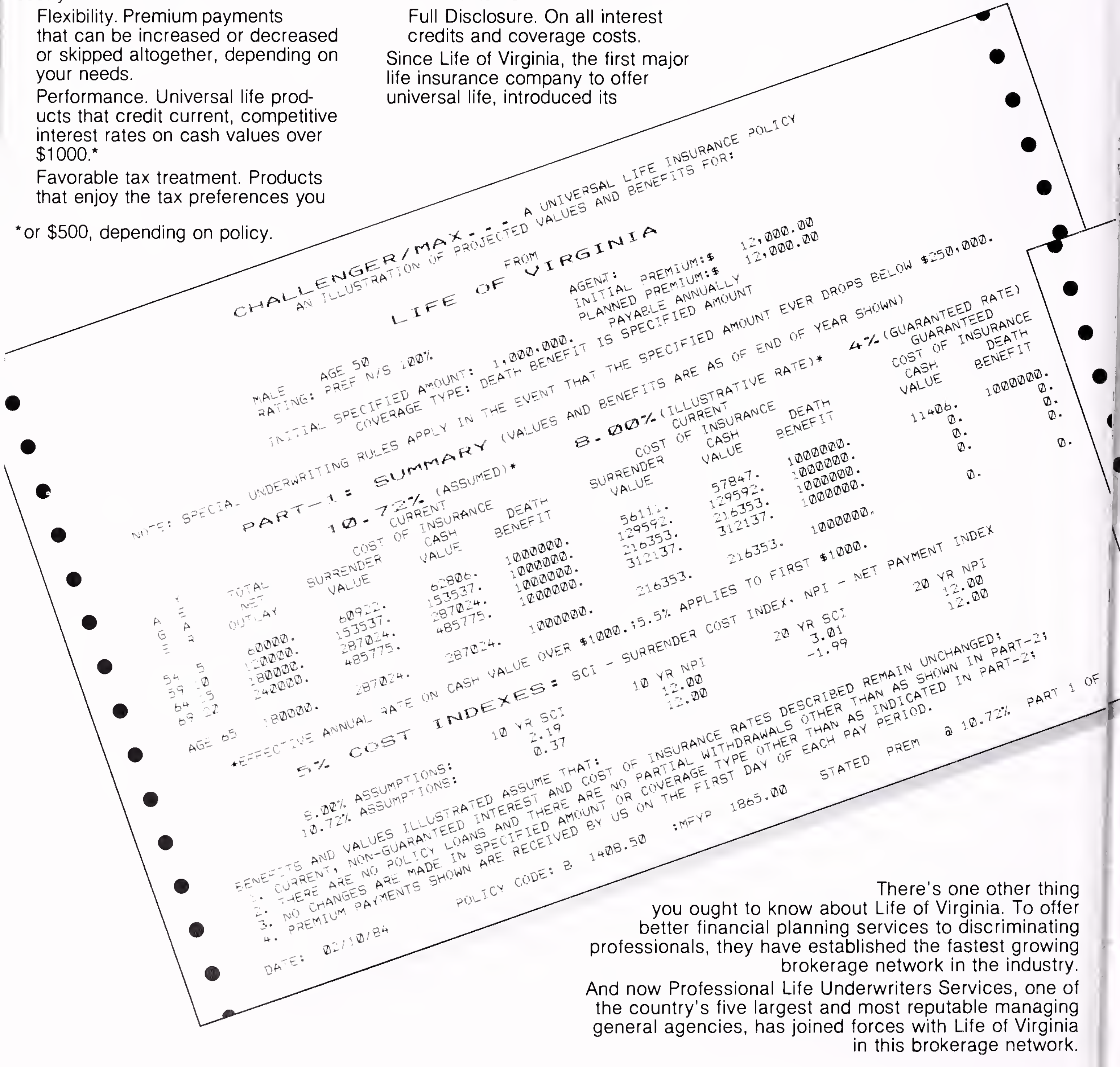
Full Disclosure. On all interest credits and coverage costs.

Since Life of Virginia, the first major life insurance company to offer universal life, introduced its Challenger policy, market acceptance has driven sales to successive records.

And Life of Virginia has stayed in front by:

—pioneering the Dual Rate Index^{SM} to give consumers maximum interest yields.

—offering the broadest universal life product portfolio in the industry.



```
CHALLENGER/MAX--- A UNIVERSAL LIFE INSURANCE POLICY
AN ILLUSTRATION OF PROJECTED VALUES AND BENEFITS FOR:
                    FROM
            LIFE OF VIRGINIA
                              AGENT:
                              INITIAL PREMIUM:$    12,000.00
                              PLANNED PREMIUM:$    12,000.00
                                PAYABLE ANNUALLY
MALE        AGE 50
RATING: PREF N/S 100%
INITIAL SPECIFIED AMOUNT:   1,000,000.
     COVERAGE TYPE: DEATH BENEFIT IS SPECIFIED AMOUNT
NOTE: SPECIAL UNDERWRITING RULES APPLY IN THE EVENT THAT THE SPECIFIED AMOUNT EVER DROPS BELOW $250,000.
   PART-1: SUMMARY (VALUES AND BENEFITS ARE AS OF END OF YEAR SHOWN)
             10.72% (ASSUMED)*               8.00%(ILLUSTRATIVE RATE)*      4%(GUARANTEED RATE)
                  CURRENT                         CURRENT                       GUARANTEED
            COST OF INSURANCE               COST OF INSURANCE             COST OF INSURANCE
    Y  TOTAL  SURRENDER  CASH     DEATH    SURRENDER  CASH     DEATH       CASH      DEATH
 A  E   NET     VALUE    VALUE    BENEFIT    VALUE    VALUE    BENEFIT     VALUE     BENEFIT
 G  A OUTLAY
 E  R
54  5  60000.   60922.   62806.  1000000.   56111.   57847.  1000000.     11406.   1000000.
59 10 120000.  153537.  153537.  1000000.  129592.  129592.  1000000.         0.         0.
64 15 180000.  287024.  287024.  1000000.  216353.  216353.  1000000.         0.         0.
69 20 240000.  485775.  485775.  1000000.  312137.  312137.  1000000.         0.         0.
AGE 65 180000. 287024.  287024.  1000000.  216353.  216353.  1000000.         0.         0.
*EFFECTIVE ANNUAL RATE ON CASH VALUE OVER $1000.;5.5% APPLIES TO FIRST $1000.
   5% COST INDEXES: SCI - SURRENDER COST INDEX. NPI - NET PAYMENT INDEX
                        10 YR SCI   10 YR NPI   20 YR SCI   20 YR NPI
 5.00% ASSUMPTIONS:       2.19        12.00       3.01        12.00
10.72% ASSUMPTIONS:       0.37        12.00      -1.99        12.00
BENEFITS AND VALUES ILLUSTRATED ASSUME THAT:
1. CURRENT, NON-GUARANTEED INTEREST AND COST OF INSURANCE RATES DESCRIBED REMAIN UNCHANGED;
2. THERE ARE NO POLICY LOANS AND THERE ARE NO PARTIAL WITHDRAWALS OTHER THAN AS SHOWN IN PART-2;
3. NO CHANGES ARE MADE IN SPECIFIED AMOUNT OR COVERAGE TYPE OTHER THAN AS INDICATED IN PART-2;
4. PREMIUM PAYMENTS SHOWN ARE RECEIVED BY US ON THE FIRST DAY OF EACH PAY PERIOD.
DATE:  02/10/84     POLICY CODE: 2  1408.50   :MFYP  1865.00    STATED  PREM   @ 10.72%   PART 1 OF
```

There's one other thing you ought to know about Life of Virginia. To offer better financial planning services to discriminating professionals, they have established the fastest growing brokerage network in the industry.

And now Professional Life Underwriters Services, one of the country's five largest and most reputable managing general agencies, has joined forces with Life of Virginia in this brokerage network.

---

*or $500, depending on policy.

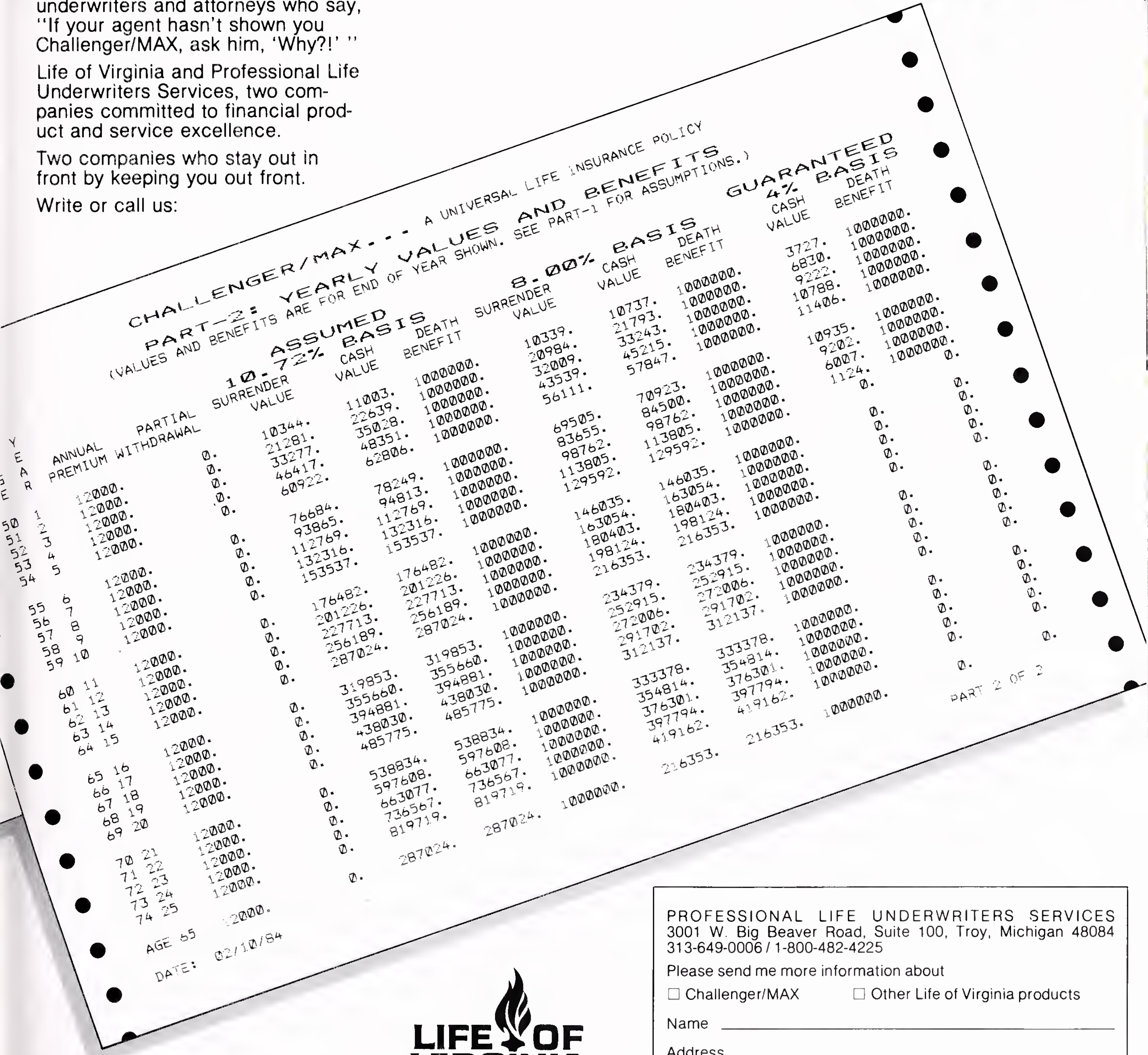
FRONT, YOU'RE PULLING AWAY

Together we offer incredibly competitive products like Challenger/MAX. Take a long look at the illustration shown here and see if you don't agree with the accountants, underwriters and attorneys who say, "If your agent hasn't shown you Challenger/MAX, ask him, 'Why?!' "

Life of Virginia and Professional Life Underwriters Services, two companies committed to financial product and service excellence.

Two companies who stay out in front by keeping you out front.

Write or call us:



CHALLENGER/MAX--- A UNIVERSAL LIFE INSURANCE POLICY

PART-2: YEARLY VALUES AND BENEFITS

(VALUES AND BENEFITS ARE FOR END OF YEAR SHOWN. SEE PART-1 FOR ASSUMPTIONS.)

				10.72% ASSUMED BASIS			8.00% BASIS			GUARANTEED 4% BASIS	
GE	YEAR	ANNUAL PREMIUM	PARTIAL WITHDRAWAL	SURRENDER VALUE	CASH VALUE	DEATH BENEFIT	SURRENDER VALUE	CASH VALUE	DEATH BENEFIT	CASH VALUE	DEATH BENEFIT
50	1	12000.	0.	10344.	11003.	1000000.	10339.	10737.	1000000.	3727.	1000000.
51	2	12000.	0.	21281.	22639.	1000000.	20984.	21793.	1000000.	6830.	1000000.
52	3	12000.	0.	33277.	35028.	1000000.	32009.	33243.	1000000.	9222.	1000000.
53	4	12000.	0.	46417.	48351.	1000000.	43539.	45215.	1000000.	10788.	1000000.
54	5	12000.	0.	60922.	62806.	1000000.	56111.	57847.	1000000.	11406.	1000000.
55	6	12000.	0.	76684.	78249.	1000000.	69505.	70923.	1000000.	10935.	1000000.
56	7	12000.	0.	93865.	94813.	1000000.	83655.	84500.	1000000.	9202.	1000000.
57	8	12000.	0.	112769.	112769.	1000000.	98762.	98762.	1000000.	6007.	1000000.
58	9	12000.	0.	132316.	132316.	1000000.	113805.	113805.	1000000.	1124.	1000000.
59	10	12000.	0.	153537.	153537.	1000000.	129592.	129592.	1000000.	0.	0.
60	11	12000.	0.	176482.	176482.	1000000.	146035.	146035.	1000000.	0.	0.
61	12	12000.	0.	201226.	201226.	1000000.	163054.	163054.	1000000.	0.	0.
62	13	12000.	0.	227713.	227713.	1000000.	180403.	180403.	1000000.	0.	0.
63	14	12000.	0.	256189.	256189.	1000000.	198124.	198124.	1000000.	0.	0.
64	15	12000.	0.	287024.	287024.	1000000.	216353.	216353.	1000000.	0.	0.
65	16	12000.	0.	319853.	319853.	1000000.	234379.	234379.	1000000.	0.	0.
66	17	12000.	0.	355660.	355660.	1000000.	252915.	252915.	1000000.	0.	0.
67	18	12000.	0.	394881.	394881.	1000000.	272006.	272006.	1000000.	0.	0.
68	19	12000.	0.	438030.	438030.	1000000.	291702.	291702.	1000000.	0.	0.
69	20	12000.	0.	485775.	485775.	1000000.	312137.	312137.	1000000.	0.	0.
70	21	12000.	0.	538834.	538834.	1000000.	333378.	333378.	1000000.	0.	0.
71	22	12000.	0.	597608.	597608.	1000000.	354814.	354814.	1000000.	0.	0.
72	23	12000.	0.	663077.	663077.	1000000.	376301.	376301.	1000000.	0.	0.
73	24	12000.	0.	736567.	736567.	1000000.	397794.	397794.	1000000.	0.	0.
74	25	12000.	0.	819719.	819719.	1000000.	419162.	419162.	1000000.	0.	0.
AGE 65		12000.	0.	287024.	287024.	1000000.	216353.	216353.	1000000.	0.	0.

DATE: 02/10/84

PART 2 OF 2

LIFE OF VIRGINIA

Professional Life Underwriters Services

3001 W. BIG BEAVER RD.
SUITE 100
TROY, MICH. 48084

PROFESSIONAL LIFE UNDERWRITERS SERVICES
3001 W. Big Beaver Road, Suite 100, Troy, Michigan 48084
313-649-0006 / 1-800-482-4225

Please send me more information about

☐ Challenger/MAX ☐ Other Life of Virginia products

Name ______

Address ______

City ______

State ______

Phone Number ______

Date of Birth ______

Predicting cancer

Findings of a research team at Henry Ford Hospital could pave the way for diagnostic tests to indicate pre-disposition to certain forms of cancer, according to Daniel Van Dyke, PhD, director of the HFH Cytogenetics Laboratory.

HFH researchers conducted a six-year study on 15 families with medullary thyroid cancer. The research project centered on chromosome changes. Using high resolution cytogenetics, researchers discovered that loss of chromosome material, known as a deletion, was evident on chromosome #20 in patients in some families with medullary thyroid cancer.

Of all the dominantly-inherited diseases, this is the first one in which this particular genetic abnormality has been found. This procedure needs to be perfected before it can be considered as a screening test for those with medullary thyroid cancer, but it is a major step.

The discovery represents the smallest known visible deletion associated with cancer in man. The findings were reported in the April proceedings of the *National Academy of Sciences.*

Survival Flight

Survival Flight, The University of Michigan Hospitals' airborne ambulance, averaged 10 weekly flights in its first year of operation, according to statistics recently compiled by the helicopter service.

"By our first anniversary in mid-May," said Kathleen LaGreca, emergency services coordinator, "we had logged 563 flights covering more than 60,000 miles — well ahead of our 500-flight goal for the first year of operation." Use of the helicopter ambulance continues to rise. "Thirty-five missions were flown in the first two weeks of May alone," LaGreca said.

Survival Flight cooperates with other hospitals, is available 24 hours a day and has a rotating crew of three pilots, eight flight nurses, four dispatchers and 20 physicians. It transports critically ill or injured patients either between hospitals or from an emergency site to appropriate hospital facilities.

Rehab Institute

The Rehabilitation Institute in the Detroit Medical Center has opened an outpatient diagnostic and evaluation center in Rochester Hills, Oakland County. According to Leonard F. Bender, MD, president of the Institute, the new satellite facility will be called Rehabilitation Institute-Oakland and represents the hospital's first facilities expansion into Oakland County.

Radiology research

General Electric Company has given The University of Michigan Medical School nearly $1 million in equipment and funds for a three-year radiology research program.

GE will provide the U-M Department of Radiology with a small-bore magnetic resonance imaging (MRI) system. The new small-bore high field MRI system will be capable of imaging small animals or body parts, such as an arm or leg. It is similar to, but more powerful than, the whole-body MRI system.

U-M researchers will use the small-bore MRI device to investigate the biochemical aspects of certain processes and to develop special contrast agents — chemicals introduced into the body to enhance imaging.

The new system includes spectroscopy capability, so U-M will not only be able to image the body part, but also to obtain chemical information as well. The new unit has a higher magnetic field than the whole-body unit and will provide more image data. It is also different in that this data will not be based on hydrogen alone. The new machine can develop data related to sodium, phosphorous and certain other atomic nuclei.

Reye's Syndrome

Two additional cases of Reye's Syndrome have been reported since April 30, the date of the last update memo. One case was a 14 year old male from Macomb County. This boy reached Stage III following an upper respiratory prodromal illness. The other case was an eight year old female from Oakland County. She did not progress past Stage 0 following a chickenpox prodromal illness.

There have been 22 cases reported in Michigan residents since October 1, 1983. Three of these cases died. Between October 1, 1982 and July 22, 1983 15 cases and two deaths were reported. Our surveillance system for influenza-like illness indicates that the influenza season has ended.

We plan to continue our medication use case-control study through next season. We only need a few more cases to attain a sufficient number of case control sets suitable for analysis. Our preliminary analysis of the data collected to date continues to support the conclusions of our previous studies.

Molecular genetics

The Howard Hughes Medical Institute and The University of Michigan have announced plans to establish a unit of the Hughes Institute at the U-M Medical Center.

The Hughes Institute will provide an estimated $8 million to construct new research facilities and to establish a core research group in molecular genetics at the U-M.

Included in the plans is construction of a second Medical Sciences Research Building, similar and adjacent to the Medical Sciences Research Building now being erected at the Medical Center. Cost of the second building will be divided between the Institute and the University.

The Hughes Institute also plans to recruit and employ three leading scientists, as well as junior

continued on page 456

Let our trust experts write the prescription for your retirement plan.

Handling your own retirement plan can be strong medicine. You can get caught up in paperwork and record keeping, end up spending more time than you'd like to, and then wonder if you've made the right decisions.

There is a way to a healthier, trouble-free retirement plan: Let the trust experts at Comerica Bank prescribe the proper management.

It's very simple. You concentrate on what you do best, and let us concentrate our expertise on your retirement plan.

This doesn't mean you can't get involved. We're very flexible. We'll do just about as much or as little as you want us to.

To make sure that your account is handled smoothly and efficiently, we assign a specific Employee Benefit officer to your account. Any time you have questions, or want to know how things are going, just call him.

Think it over. We can take a big load off your back and off your mind.

Call Terrence E. Keating at (313) 222-3898, or write to him at Comerica Bank-Detroit, P.O. Box 59, Detroit, MI 48232.

Let us know when we can start. After all, you're the doctor.

Comerica
BANK

From One of the Oldest Medical Computer Companies in Michigan

COMPLETE MEDICAL OFFICE COMPUTER DESIGNED FOR MICHIGAN PHYSICIANS

$6300

Includes
- IBM PC XT
- Program
- Training Class

Call or Write Today

Bennethum Computer Systems, Inc.
31811 Middlebelt Rd.
Suite 202
Farmington Hills, MI 48018
313/851-3058

— Since 1968 —

faculty members and research staffs. The Institute will equip, supply, and maintain the new laboratories.

Founded in 1953 by the late industrialist/aviator Howard Hughes, the Hughes Institute conducts medical research in laboratories affiliated with leading academic medical centers, particularly in the areas of genetics, immunology, neuroscience and metabolic regulation.

Laboratories have been established by the Hughes Institute so far at 15 medical centers, including Columbia, Johns Hopkins, Harvard, Duke, Baylor Medical College, Yale, Vanderbilt, and University of California at San Francisco.

Rainbow Connection

St. Joseph Hospital-Flint has made a major investment in a "future generation of employees" through a unique human relations program, the "Rainbow Connection."

Last year, the hospital launched the "Rainbow Connection," a program designed to sensitize employees to the special "human" needs of patients and visitors, as well as the needs of other employees and physicians in the highly stressful health care environment.

The first phase, "Communication through Understanding," was designed to introduce employees to the value and need to communicate in the workplace, emphasizing skills that can be immediately applied on and off the job.

The second phase, "Coping through Understanding," helps employees deal with their day-to-day stress and other work-related problems through stress management and health education.

Future themes will relate to the connection of empathy and concern for patients and the role of health care professionals.

An evolutionary and long-term program, the Rainbow Connection, Phase I, was presented to employees last fall through 64 workshops. It focused on effective interpersonal communication skills and building better relations between employees. Participants developed personal action plans and were encouraged to practice their skills on the job.

The first phase also established an Employee Recreational Committee. The committee encourages employee involvement in the hospital and recreational activities, and is run by employees.

Speed changes

New research by a University of Michigan neuroscientist indicates that a single exposure to amphetamine or "speed" may produce a permanent change in some nerve cells in the brain.

"It is well-established that repeated doses of amphetamine result in a progressively enhanced behavioral response — a phenomenon called 'behavioral sensitization,' " Terry E. Robinson, assistant professor of psychology, explained.

"Our research with laboratory rats indicates that multiple injections may not be necessary to produce these enduring changes in behavior. Even a single injection of amphetamine may produce changes in the brain that are very long-term or permanent."

The findings have important implications for humans, Robinson believes — both those who use the drug therapeutically and the untold numbers of others who take it illicitly.

"Chronic amphetamine use in humans may lead to the development of an 'amphetamine psychosis' that is nearly indistinguishable clinically from paranoid schizophrenia."

Cocaine, which seems to be one of the most popular recreational drugs at the moment, is also a psychomotor stimulant that increases brain dopamine activity, Robinson added. A paranoid schizophrenic-like condition like amphetamine psychosis may develop with chronic cocaine use.

Hematology:
Advance Medical & Research Center, Inc. offers the rapidity of automation and internal control parameters required for individual observation of patient results. Specialists in hematology work closely with the pathologist in providing complete and professional followup to our client accounts.

ADVANCE MEDICAL & RESEARCH CENTER, INC.
1270 Doris Rd. • Pontiac, Michigan 48057 • (313) 373-9120
Branches: Allen Park, Alpena, East Jordan, Flint,
Grand Rapids, Kalamazoo, Lansing, Monroe, Traverse City

Serving the medical profession since 1963

Patients sought for Lafayette Clinic studies

The Lafayette Clinic is located at 951 E. Lafayette Avenue, Detroit, 48207.

Elderly patients with dementia and depression

In geriatric patients (beginning at around 55 years of age) the differentiation between dementia of the Alzheimer type or other forms of dementia and major affective disorder is frequently difficult, especially at an early stage of the illness.

We are interested in studying patients whose diagnosis is not established and especially who are at an early stage of the illness. There is evidence that some patients may present with aphasia as an early and most prominent symptom of dementia.

Patients will be hospitalized at Lafayette Clinic where psychiatric, neurological, and neuropsychological work up will be performed. The costs of hospitalization for the research period of admission will be covered.

For details, contact David Gurevich, MD, PhD, (313) 256-9405.

Depressed patients

Two investigational antidepressants are now being tested in the Outpatient Department at Lafayette Clinic in controlled, double-blind studies. One drug is clovoxamine, a drug that has not yet been marketed. The other drug is indalpine, which is currently available in France. Both drugs are of interest because they appear to have milder side effects than conventional antidepressants. Treatment is free.

For details, contact Robert Pohl, MD, (313) 256-9585.

Anxiety disorder program

For the past two years, panic disorder patients have been studied at Lafayette Clinic with infusions of drugs that provoke panic attacks in the laboratory. Each patient is infused with glucose, isoproterenol and lactate over a three-week period; both isoproterenol and lactate provoke panic attacks.

The main object of the study is to measure a variety of biological variables before, during and after the attack and to compare them to normal controls, who do not have panic attacks during the infusions. Treatment is provided after the study free of charge for three months.

For details, contact Robert Pohl, MD, (313) 256-9585 or John Rainey, MD, (313) 256-9553.

Women's sleep-wake patterns

The Nursing Department at Lafayette Clinic is conducting a study of women's sleep-wake patterns. To be in the study women must be between 40 and 69 years of age and have a history of being hospitalized for depression. Women who participate in the study are asked a number of questions about their sleep and activity patterns and then keep records for one week about how they slept at home. Upon returning all completed forms to the Clinic, women are given $20.00.

For details, contact Ms. Denison, RN, L.C. Outpatient Department, (313) 256-9569.

Parkinsonism and related movement disorders

Several studies have been initiated or are in planning for treating advanced Parkinsonism with "on-off" effects or dyskinesias, or other complications of conventional therapy. Several medications will be used as supplements to Levodopa and other drugs in these trials: Pemoline, Buspirone, Mesulergine, Budipine, and SKF 38393 are among new compounds in various stages of pharmaceutical development for human trials. In addition, other approaches will be employed to try to achieve improved control of Parkinsonism symptoms.

Other movement disorders under study include dystonia (such as spasmodic torticollis, writer's cramp, or dystonia musculorum deformans), tremor, blepharospasms, and Gilles de la Tourette Syndrome.

For details, contact Peter LeWitt, MD, Neurology Department, (313) 256-9405.

Depressed patients and their families

Preliminary studies conducted at Lafayette Clinic suggest the presence of a cholinergic hypersensitive response, or "trait marker" in subgroups of endogenous depressed patients. To test this hypothesis and to substantiate a possible "genetic marker," i.e. Cholinergic REM Induction Response, a family study of depression is being conducted in the Affective Disorders Unit of Lafayette Clinic. This entails a full evaluation and treatment to those who quality. Inclusion criteria are as follows:

1) Patients with depression and a family history of affective illness in at least one close relative, ages 18 through 50.

2) Willingness of one or more close relatives to participate in the study.

3) All participants be free of major medical problems.

Potential subjects first come in for a complete physical and neurological examination. They are then required to sleep in the sleep laboratory four consecutive nights were polysomnographic recordings and infusion of arecoline are monitored. A fibroblast QNB binding (skin biopsy) and pupillary miotic response also are conducted to test the same hypothesis.

For details, contact Ms. C. Musckiewicz, MSW, (313) 256-9612.

continued on page 460

1953.

- General Dwight D. Eisenhower was inaugurated President of the United States; his vice president was Richard M. Nixon.
- The Korean armistice was signed to end the Korean War.
- Not one home owned an electronic calculator or color TV.
- It cost 3¢ to mail a letter.
- The Studebaker was the "new American car with the European look."
- Jacqueline Bouvier was engaged to U.S. Senator John F. Kennedy; **and**
- **the Stratton Agency began serving the Michigan State Medical Society!**

We have appreciated your participation and support over the past 30 years. If you would like additional information about our services, we would be happy to hear from you.

STRATTON-CHEESEMAN & ASSOCIATES, INC.
1305 Abbott Road, P.O. Box 1563
East Lansing, Michigan 48823

800-292-1926

Patients needed for these U-M studies

Librium, Inderal

The University of Michigan Department of Psychiatry is seeking volunteers for a research study designed to assess the efficacy of chlordiazepoxide (Librium) and of propranolol (Inderal) in the treatment of Generalized Anxiety Disorder. Generalized Anxiety Disorder is characterized by persistent anxiety of at least one month's duration with signs and symptoms such as motor tension, autonomic hyperactivity, apprehensive expectation, hypervigilance, or feelings of being "on edge."

Diagnostic workups, including in-depth interviews, medical history, physicial examination and laboratory studies are free to subjects who qualify. Close monitoring of drug response and disposition arrangements for further treatment, if needed, also are free.

The trial lasts five weeks. George C. Curtis, MD, professor of psychiatry and director of the Anxiety Disorders Program, is principal investigator of the study.

Further information may be obtained, or referrals arranged, by calling the Anxiety Disorders Program at (313) 764-5348.

Xanax, Tofranil

The University of Michigan Department of Psychiatry is seeking volunteers for a research study designed to assess the efficacy of alprazolan (Xanax) and imipramine (Tofranil) in the treatment of Panic Disorder, with or without agoraphobia or other phobic symptoms. Panic disorder is characterized by sudden surges, often unexpected, of apprehension or panic, with many of the following symptoms: dyspnea, palpitations, chest pain or discomfort, choking or smothering sensation, dizziness or unsteady feelings, depersonalization, paresthesias, hot and cold flashes, diaphoresis, faintness, trembling or shaking, and fear of dying, fears of madness, or loss of control. Attacks usually last a few minutes to an hour or more.

Diagnostic workups, including in-depth interviews, medical history, physical examination and laboratory studies are free to subjects who qualify. Close monitoring of drug response and disposition arrangements for further treatment, if needed, also are free.

The trial lasts 13 weeks. George C. Curtis, MD, professor of psychiatry and director of the Anxiety Disorders Program is principal investigator of the study.

Further information may be obtained, or referrals arranged by calling the Anxiety Disorders Program at (313) 764-5348.

LAFAYETTE/Continued

Drug treatment of dementia

Individuals with Alzheimer's disease and/or multi-infarct dementia (MID), a disorder secondary to repeated strokes, are presently needed at the Lafayette Clinic to participate in a project directed at the treatment of memory loss in these conditions by means of a novel, experimental drug. Those individuals who qualify will be treated at no cost. All patients entered into the study will receive a full neurological, medical and psychiatric evaluation.

For details, contact Mary Russell, RN, Geriatric Study-Treatment Program, (313) 256-9542.

Treatment for marital problems

Two approaches to marital therapy have been shown to be generally effective with couples whose relationship problems are related to deficits in communication, problem-solving, and decision-making skills.

Whether or not some personality and interpersonal characteristics will predict a more favorable response using one approach or the other is the focus of an NIMH-funded study using insight oriented and behavioral marital therapies. We welcome referrals of couples who want to work on their marriages and where there are no complications from alcoholism, drug abuse, family violence, or where the couple no longer is living together. Couples will receive the entire course of marital therapy without charge.

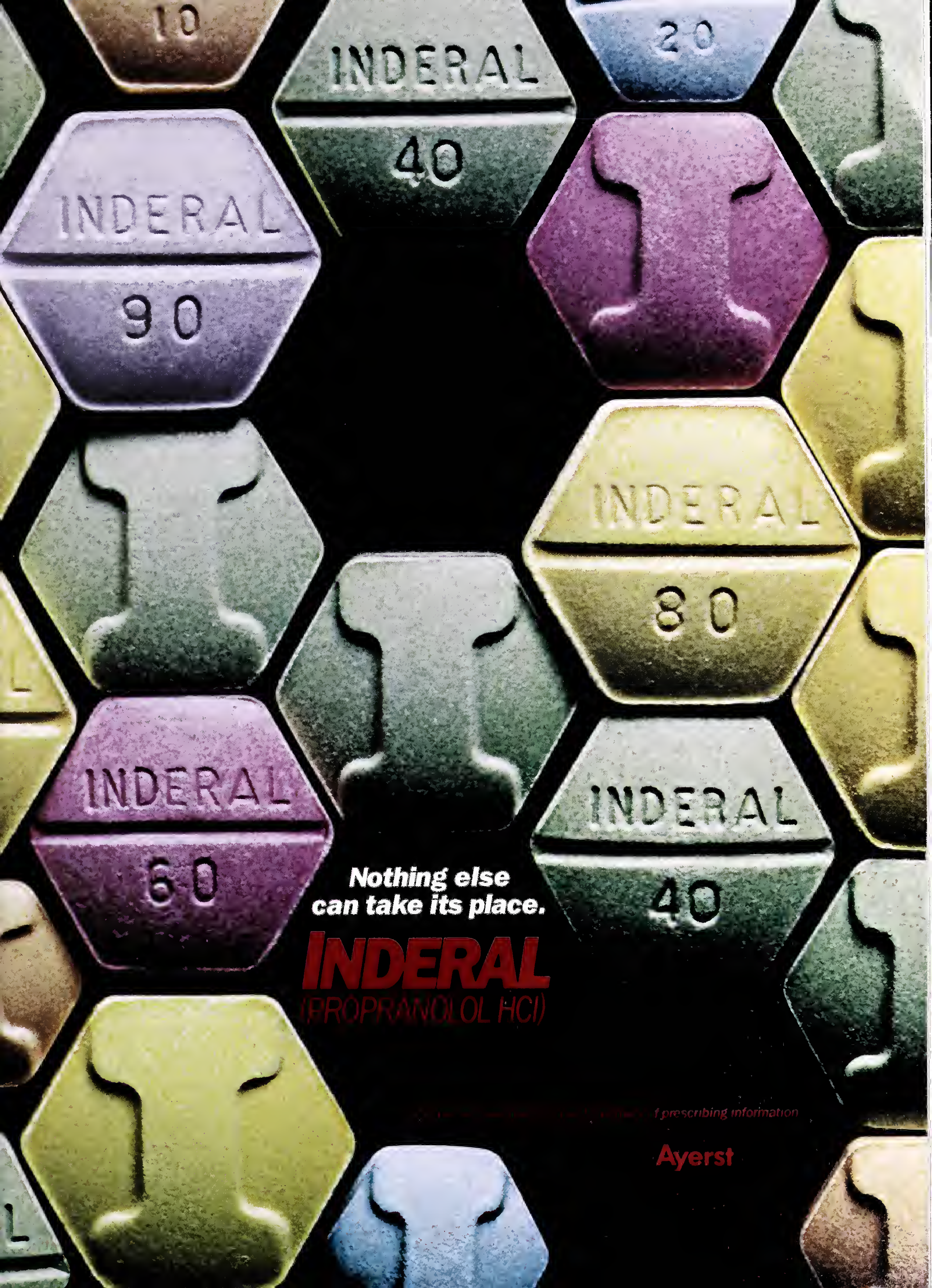
For referrals, couples may call (313) 256-9569. Professionals seeking information may call Robert M. Wills, ACSW, Lafayette Clinic, Detroit 48207, (313) 256-9488.

Children in trouble

"Listen to the Children" is the title of a new brochure offered by the National Association of Social Workers, headquartered in Silver Spring, MD. The brochure, with the purpose of serving as a "child protection guide for parents," aims to help parents detect signs of drug or alcohol usage, depression, runaway potential, physical or sexual abuse, or other serious problems.

The brochure describes eight ways to learn if a child is in trouble, and eight ways to listen well to a child. "Often you can help your children avoid trouble simply by listening," says the pamphlet.

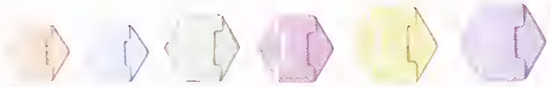
Copies are available from Sheri Greenhoe, Communications Specialist, Michigan Chapter, NASW, 230 N. Washington Square, Suite 212, Lansing, 48933.


Nothing else
can take its place.
INDERAL
(PROPRANOLOL HCl)
[illegible] f prescribing information
Ayerst

Nothing else can take its place.

INDERAL®

(PROPRANOLOL HCl)



BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

INDERAL® (propranolol hydrochloride) Tablets

CLINICAL PHARMACOLOGY

The Beta-Blocker Heart Attack Trial (BHAT) was a National Heart, Lung and Blood Institute-sponsored multicenter, randomized, double-blind placebo-controlled trial conducted in 31 U.S. centers (plus one in Canada) in 3,837 persons without history of severe congestive heart failure or presence of recent heart failure; certain conduction defects; angina since infarction, who had survived the acute phase of myocardial infarction. Propranolol was administered at either 60 or 80 mg t.i.d. based on blood levels achieved during an initial trial of 40 mg t.i.d. Therapy with INDERAL, begun 5-21 days following infarction, was shown to reduce overall mortality up to 39 months, the longest period of follow-up. This was primarily attributable to a reduction in cardiovascular mortality. The protective effect of INDERAL was consistent regardless of age, sex or site of infarction. Compared to placebo, total mortality was reduced 39% at 12 months and 26% over an average follow-up period of 25 months. The Norwegian Multicenter Trial in which propranolol was administered at 40 mg q.i.d. gave overall results which support the findings in the BHAT.

Although the clinical trials used either t.i.d. or q.i.d. dosing, clinical, pharmacologic and pharmacokinetic data provide a reasonable basis for concluding that b.i.d. dosing with propranolol should be adequate in the treatment of post-infarction patients.

CLINICAL. In the BHAT, patients on INDERAL were prescribed either 180 mg/day (82% of patients) or 240 mg/day (18% of patients). Patients were instructed to take the medication 3 times a day at mealtimes. This dosing schedule would result in an overnight dosing interval of 12 to 14 hours which is similar to the dosing interval for a b.i.d. regimen. In addition, blood samples were drawn at various times and analyzed for propranolol. When the patients were grouped into tertiles based on the blood levels observed and the mortality in the upper and lower tertiles were compared, there was no evidence that blood levels affected mortality.

PHARMACOLOGIC. Studies in normal volunteers have shown that a 90 mg b.i.d. regimen maintains beta blockade at, or above, the minimum for 60 mg t.i.d. dosing for 24 hours even though differences occurred at two time intervals. At 10-12 hours after the first dose of the day, t.i.d. dosing gave more beta blockade than b.i.d. dosing; at 20-24 hours the trend of the relationship was reversed. These relationships were similar in direction to those observed for plasma propranolol levels (see Pharmacokinetics).

PHARMACOKINETIC. A bioavailability study in normal volunteers showed that the blood levels produced by 180 mg/day given b.i.d. are below those provided by the same daily dosage given t.i.d. at 10-12 hours after the first dose of the day but above those of a t.i.d. regimen at 20-24 hours. However, the blood levels produced by b.i.d. dosing were always equivalent to or above the minimum for t.i.d. dosing throughout the 24 hours. In addition, the mean AUC on the fourth day for the b.i.d. regimen was about 17% greater than for the t.i.d. regimen (1,194 *vs.* 1,024 ng/ml• hr).

CONTRAINDICATIONS

INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS

CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

> IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema) — PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL (propranolol hydrochloride) should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL, like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS

General. Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy. Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure, intensification of AV block, hypotension; paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

*The appearance of INDERAL tablets is a registered trademark of Ayerst Laboratories.

8965/284

Ayerst®
AYERST LABORATORIES
New York, N.Y. 10017

Our greatest strength lies in joining together

The following excerpts are taken from the exaugural address given June 27 by Susan E. Adelman, MD, Detroit, as she relinquished the presidency of the Wayne County Medical Society. Her remarks have meaning for physicians across the state, and thus they are printed here.

Where does a county medical society fit in? At one time, this was one of the few medical organizations to represent the physician; now there are specialty societies, ethnic societies, hospital staffs, and a host of others. A legitimate question can be asked whether a county medical society can do this as well or better. It seems to me, as it did last year, that the answer is yes.

Through our federation with the AMA, we have by far the greatest resources of any medical organization to keep up with current socioeconomic and scientific developments, just as we have the greatest capacity of all to understand, to explain, to interpret and to act as an advocate for the physician on the basis of this knowledge.

We can act to modify some current develoments. We can educate the public, ourselves and our third party payers. We cannot, however, engage every adversary in full-scale war — unless we want a massive increase in dues.

It is interesting to note that the AMA, our umbrella organization, too is caught in a dilemma. It is at once accused by its critics outside the profession of being too powerful and by its critics within the profession of not being powerful enough — "not doing anything," they say. I think there is a lesson in that somewhere — maybe about the nature of critics.

Linkages

One thing this (medical) society can do is create linkages. We can link the profession as a whole, and we can represent the profession as a whole. We also can work to clean up our profession as a whole, using membership.

If we insist that membership in our society be a symbol of ethical practice and if we strictly enforce our standards, we may invite lawsuits. But it would give us a unique moral force in representing our profession to the outside world.

It would also help us address the problem of discipline within our profession. Our federation is already working with the Michigan Board of Medicine to keep up our professional standards. We must be more effective than we are today. It would be nice to stop reading about how ineffective we are in policing ourselves when we open the morning newspapers. . . .

It is of critical importance to our medical profession that we do not allow ourselves the self-indulgence of being drawn into positions where one medical society is pitted against another.

The medical profession today has enough external enemies who will be gratified beyond words if we dissipate all of our energies fighting among ourselves.

Remember, the amount of time and energy which we can afford to take away from our practices is finite. If we use it fighting each other, we will not be able to use it to deal with the outside forces which confront us all.

Whatever our apparent differences, I am absolutely convinced that what we have in common is far more important.

Currents

Differences between physicians vary from issue to issue and from year to year. Configurations change. Some years, private practitioners are at odds with the physicians staffing hospital clinics and satellites. Some years whole hospital staffs are at odds with their hospitals. Some years see fighting between specialists. Some years BCBSM zaps all the specialists, and they are happy to join together to fight BCBSM. Some years the malpractice crisis divides us, and some years it unites us all.

We need to remember that these are all just the many cross currents generated by the many pressures brought to bear on our profession from the outside. These currents shift and change, though, and the divisions between different groups of physicians shift like the sands and the sea — no matter how cross the currents look at the time.

The link between us all is that we want to do our thing, practice medicine in the best way we know how, with a minimum of harmful intrusion. We must not become divided and impotent. Our greatest strength lies in joining together — in each of us going out and bringing one new member into the WCMS, on and on, until the whole ethical physician community has joined. Then everyone's interests will be represented, even if everyone's interests are not congruent.

By Sander J. Breiner, MD

How others view us: control from the outside

In July, 1983, the American Academy of Political and Social Science published its Annals. Each issue of the Annals is a specially arranged document, book-size in length, in which a special editor of that volume is selected, a topic is arranged for and special authors are selected to write about various facets of that topic.

Theoretically, each topic is covered in depth from a variety of important views. Supposedly, it is unbiased and expresses the opinion and judgment and knowledge of people in government, out of government and from various sides of an issue.

The issue that was selected for the July 1983 publication was "Health Care Policy in America." The editor is S. E. Berki, professor and chairman, Department of Medical Care Organization, School of Public Health, University of Michigan.

Berki writes a preface to the issue that sets the tone for what is contained therein. Following is an exact quote from the end of his preface:

"Policy issues of the next two decades will be framed not only by the social dynamics of population aging and technological advances, but by institutional changes as well. An increasing supply of physicians (Ginsburg) within an industry undergoing rationalization and corporatization (Zuckerman) is likely to lead to a fundamental shift in the balance of power among medicine, corporate manager, and government.

"The present search for alternative health care policies is seen by Berki as fundamentally a clash between liberal and libertarian moral values, a search for a low cost system of social justice. If the past is any guide, and if the aging poplation and the expansion of the power to heal, maintain, and ameliorate will continue, devising fair systems of resource allocation and distribution in the future will pose a difficult conundrum. Unless society devotes an ever increasing share of its resources to health care, permitting its distribution on the basis of private, individual need, or unless its distribution by markets on the basis of prices acceptable, a system of rationing based on social needs will have to be developed. Within tightening resource constraints, neither the pro competitive strategies nor the approaches of the past two decades are likely to yield distributional decisions consonant with social justice.

"If the past is any guide, the analytic vigor honed in the present debate should serve well the cause of developing the needed policies of the future."

From the preceding you can see that what follows is meant to be a base or primer for future planning for the medical "industry."

The final article is essentially a summation by the editor titled "Health Care Policy: Lessons from the Past and Issues of the Future."

He says the main problems are how to ration scarce health resources, meaning dollars, and how to provide more extensive care to the problems of the aged. By implication this means government control of health care dollar expenditures.

He views the future as a certainty that there will be a severe competition for resources among the various sectors and interest groups in society that will not support a guns and butter philosophy. He sees that the cost of health care is likely to continue to increase as a share of the GNP. He also sees this cost increase will not be easily tolerated by the mass of society. But he does see that pluralism in health care activities will continue. He sees a necessity for some sort of "rationing within the health care field."

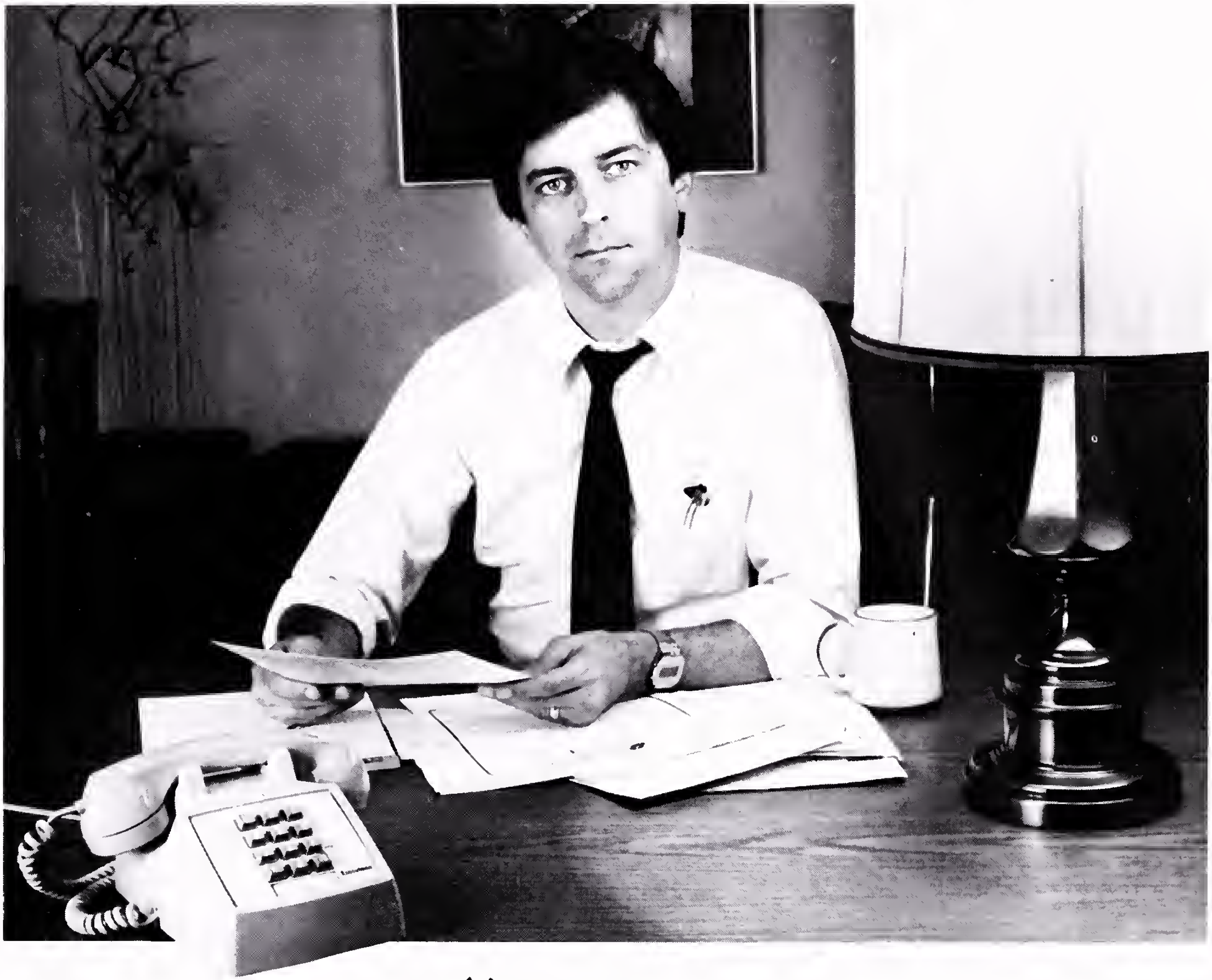
Summary and conclusions

I wish everyone to observe that in the thinking and planning for the future of medicine in America, people who are not part of the medical scene per se are writing papers and thereby making plans for the future of medicine. In all of this material there is no direct reference to doctors and how they think and feel about the situation, what their recommendations are and how they view the future of medical care in our country.

Further, there is no input into the psychological components that are an important part of the health care situation, both as it is experienced as a patient as well as by the monetary concerns of the consumer.

In other words, people with little to no understanding of the psychology of medical care are in the process of making determinations for doctors, which include psychiatrists, on how they are going to function in the near future.

Doctor Breiner, of Birmingham, is a psychiatrist.



"...Your financial security specialist is on call"

American Physicians Life believes a physician's financial security deserves specialized attention. That's why our products and services are designed with the doctor in mind. Our comprehensive portfolio of services, including life insurance, professional disability income coverage, qualified plans and tax-deferred annuities, is customized to meet your personal financial planning needs as well as those of your professional corporation.

Let American Physicians Life secure your financial planning program—that's our specialty!

Call today for the financial security specialist in your area.

AMERICAN PHYSICIANS LIFE
Bates Drive, P.O. Box 281
Pickerington, Ohio 43147
Telephone (614) 864-3900

Toll-free in Ohio, 1-800-282-7515
Toll-free outside Ohio, 1-800-742-1275

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

1st FOR PROFESSIONAL PROTECTION EXCLUSIVELY

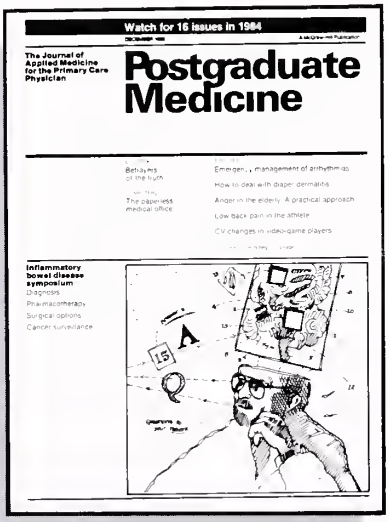
YOUR FIRST STEP TO FIRST QUALITY PROTECTION
CONTACT FIELD REPRESENTATIVES

Eastern Office
JOHN K. GALLOWAY, THOMAS A. WEISMAN, WAYNE M. BACKUS,
CHARLES J. ROWE and MARK A. WHITMAN
6785 Telegraph Road, Suite 350, Birmingham, Michigan 48010
(313) 647-6640

Western Office
GEORGE J. HAWORTH
2600 Five Mile Road, NE, Suite 101
Grand Rapids, Michigan 49505
(616) 361-0863

TURN
TO POSTGRADUATE MEDICINE

Your single, most important source of information on General and Internal Medicine!



Watch for 16 issues in 1984

A McGraw-Hill Publication

The Journal of Applied Medicine for the Primary Care Physician

Postgraduate Medicine

Betrayers of the truth

The paperless medical office

Emergency management of arrhythmias

How to deal with diaper dermatitis

Anger in the elderly: A practical approach

Low back pain in the athlete

CV changes in video-game players

Inflammatory bowel disease symposium
Diagnosis
Pharmacotherapy
Surgical options
Cancer surveillance

Each issue filled with diverse practical information in all areas of medical practice including:

- IM Subspecialties
- Pediatrics
- Obstetrics/Gynecology
- Emergency Medicine
- Other Key Clinical Areas

Read every issue
Postgraduate Medicine
Where Clinical Diversity is an Art.

BALANCED CALCIUM CHANNEL BLOCKADE!

CARDIZEM®
(diltiazem HCl)
balances potent coronary vasodilation with a low incidence of side effects

Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

Please see full prescribing information on following page.

2/84

---

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:

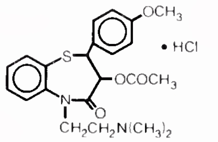
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy)-5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+)-cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral/LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 4/1/84

Another patient benefit product from
PHARMACEUTICAL DIVISION
MARION
LABORATORIES, INC.
KANSAS CITY, MISSOURI 64137

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Genoveva A. Bautista, MD — PD
23323 Teppert
East Detroit 48021

James E. Benecke, MD — OTO
22000 Greenfield
Oak Park 48237

Terrance M. Brady, MD — DR/C
2022 Fair St.
Ann Arbor 48103

Patricia J. Campbell, MD — P
1025 Barton #210
Ann Arbor 48105

Brian Chodoroff, MD — PM
1203 Broadway
Ann Arbor 48105

Curt P. Comstock, MD —
820 Fuller #108
Ann Arbor 48105

Michael B. DeLong, MD — GS/CDS
274 E. Chicago
Coldwater 49036

Mark D. Dykowski, MD —
3235 Coolidge
Royal Oak 48072

John D. Everett, MD — AN
2140 Butternut
Okemos 48864

Angel Gomez-Galan, MD —
9643 Laurence
Allen Park 48101

George P. Grillo, MD — GPM/PH
1200 Byron Rd.
Howell 48843

Mark E. Grosinger, DO — OTO
27200 Parkview #515
Warren 48092

Isabel L. Guerra, MD — IM
3080 Shattuck Arms Blvd. #9
Saginaw 48603

Richard S. Hagelberg, MD — GS
3537 W. Front St.
Traverse City 49684

Jeffrey C. Hamm, MD — PS
1930 Dunmore
Ann Arbor 48103

William B. Hampton, MD — IM
550 Osborn Blvd.
Sault Ste. Marie 49783

James A. Kolberg, MD — GS/GP
211 S. High St.
Northport 49670

Manus Krasman, MD — IM/GE
21340 Glenmorra
Southfield 48076

Paul J. Lentz, MD — FP
1630 McIntyre Dr.
Ann Arbor 48105

Marjan Mohamadi, MD — IM
300 E. Chicago
Coldwater 49036

Joseph B. Naoum, MD — CD/IM
133 S. Gratiot
Mt. Clemens 48043

Robert L. Pacer, MD — IM
3537 W. Front St.
Traverse City 49684

John C. Putz, MD — ORS
2316 S. Cedar St.
Lansing 48910

Jorge L.Rodriguez-Mendez, MD
11948 13 Mile Rd. #103
Warren 48093

Edward A. Rose, MD — FP
16254 Mayfair #101
Southfield 48075

Abdul R. Sadik, MD — R
1401 S. Washington Ave.
Royal Oak 48067

Mark R. Sadzikowski, MD — IM
6033 Middlebelt Rd.
Garden City 48135

Daniel J. Sak, MD — PUD
1575 Woodward #104
Bloomfield Hills 48013

Donald J. Scholten, MD — GS
100 Michigan, NE
Grand Rapids 49503

Stanley R. Sherman, MD — GS
1001 Carrier Creek, NE
Grand Rapids 49503

Alan K. Silverman, MD — IM/D
1437 Natalie Lane #117
Ann Arbor 48105

Charles G. Skardarasy, MD —
21325 Sloan Dr. #205C
Harper Woods 48225

John L. Tofaute, MD — ORS/OM
24157 Van Dyke
Centerline 48015

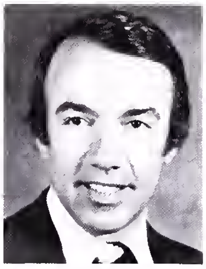
Hugo M. Uhland, MD — IM
1000 Houghton
Saginaw 48602

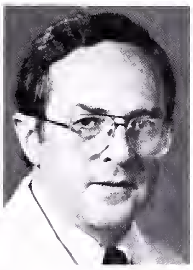
Dante F. Vacca, MD — NS
1350 W. Bethune #1006
Detroit 48202

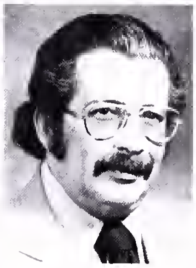
Georgia J. Westermeyer, MD — PD
300 Western Apt. C-222
Lansing 48917

Eugenia A. Young, MD — PD/ADL
26206 W. 12 Mile Rd.
Southfield 48034

By Joyce Crum


Blondy


Goldstein


Krome

David M. Reifler, MD, Grand Rapids, wrote an article that appeared in the February issue of the Archives of Ophthalmology. The article presented a new technique in the diagnosis of metastatic cancer. **Don Liu, MD, Sudha Kini, MD and Ray Littleton, MD,** all of Detroit, cooperated on the article ... Taking office in October as president of the American Association of Automotive Medicine is **Marshall J. Blondy, MD,** Livonia. He is the first pediatrician chosen to head AAAM, which promotes car passenger safety and includes physicians, nurses, engineers, automobile manufacturers and insurance companies ... **Sidney Goldstein, MD,** Detroit, has been elected to serve as Michigan governor of the American College of Cardiology's Board of Trustees. Governors are responsible for reviewing all applications for membership to the ACC within their areas and for making recommendations to the ACC Credential Committee ... **Raymond D. Sphire, MD,** Detroit, has been elected to a fifth consecutive term as chief of staff of the Detroit-Macomb Hospital ... **Stephen J. Mathes, MD,** San Francisco, is the new head of plastic and reconstructive surgery at the University of Michigan Medical School ... **Shirley Jenkins Phelps, MD,** Ann Arbor, has been elected director-at-large of the American Lung Association. She will serve on the national board of directors until May, 1987 ... **Ronald L. Krome, MD,** Southfield, is the new president of the American Board of Emergency Medicine. He has been a member of the board since its inception ... **James O'Neill, MD,** was pre-

---

Mrs. Crum is secretary to *Michigan Medicine.*

LABORATORY OF CLINICAL MEDICINE
MID-MICHIGAN REFERENCE LABORATORY, II, Inc.
(517) 372-8180

1322 E. Michigan Ave.
Suite 211
Lansing, Michigan 48912

930 E. Mt. Hope Ave.
Lansing, Michigan 48910

2909 E. Grand River Ave.
Suite 104
Lansing, Michigan 48912

W. E. Maldonado, M.D.
Director

Robert B. Foy, Ph.D.
Chief Executive Officer

Ann E. Chernys, M.D.
John W. Dyke, Ph.D.
Dennis E. Freer, Ph.D.
John J. Gillespie, M.D.
Ronald N. Horowitz, M.D.
John R. Kateley, Ph.D.

LABORATORY OF CLINICAL MEDICINE
MID MICHIGAN REFERENCE LABORATORY

John J. Lyday, M.D.
Joseph R. Melvin, Ph.D.
Sandra K. Shirley, M.D.
Laurence R. Simson, Jr., M.D.
Susan M. Strate, M.D.
Irene K. Trombley, M.D.

REFERENCE LABORATORY FOR SPECIALIZED PROCEDURES
Specimen Pickup and Delivery of Test Results Daily
House calls are available upon Physician's request
Assignment is accepted from Medicare, Medicaid, Blue Shield and all other insurance carriers.

sented the Super Person Special Award at the Independence Township Sixth Annual Community Awards Ceremony. Doctor O'Neill was honored for his donation of physicals, his care of the priests at Colombiere and his interest in local politics ... **Boy Frame, MD,** Grosse Pointe Park, has been asked to join NASA's Life Sciences Advisory Committee to study bone loss and other problems associated with prolonged space flights ... Elected to his second three year term on the Board of Trustees of the American Heart Association of Michigan is **John Bielawski, MD,** Dearborn ... **Arthur A. Ulmer, MD,** Grosse Pointe Shores, has been installed as president of the medical staff of Saint John Hospital. He succeeds **William McIntyre, MD,** Detroit. The new president-elect is **Jacques Beaudoin, MD,** Grosse Pointe Park. Doctor Ulmer is a member of the MSMS Board of Directors ... **James H. Sondheimer, MD,** Farmington Hills, has been appointed vice chief of nephrology at the Harper Hospital Division of Harper-Grace Hospitals ... **Alfred B. Swanson, MD,** Grand Rapids, is the recipient of the Distinguished Service and Health Care Award from the Hospital Council of West Michigan. He also presented "The Long-term Results in Implant Arthroplasty of the Forefoot" at the 97th Annual Meeting of the American Orthopaedic Association held recently in Palm Beach, Florida ... The American Academy of Thermology has released the results of its accreditation examinations in thermography. Among those qualifying for board certification is **Donald Lawrence Newman, MD,** Southfield. The tests are the first such examinations in the field of thermography ... **W. E. Maldonado, MD,** Lansing, is among a group of physicians throughout the country who have been recognized for excellence in medical management and have been certified by the American College Physician Executives ... **Walter L. Anderson, MD,** Grosse Pointe Woods, is retiring after 50 years of service at Harper-Grace Hospitals. He also was clinical associate professor and clinical professor at Wayne State ... **George A. Kling, MD,** Grosse Pointe Farms, is the new Chairman of the Department of Radiology of the Wayne State University School of Medicine. He will continue as Chief of the Department of Radiology at Harper-Grace Hospital and his clinical positions with Children's Hospital of Michigan and Detroit Receiving Hospital ... Newly elected as president of the Southeastern Michigan Surgical Society is **Elie D. Aboulafia, MD,** Farmington. He also serves on the staffs of Sinai, Botsford General, Detroit Memorial, North Detroit General and Crittenton hospitals. Elected as president-elect is **Allen Silbergleit, MD,** Pontiac.

HEALTH PROFESSIONALS!

The Army Medical Department represents the largest comprehensive system of health care in the United States and offers unique advantages to the student, resident, and practitioner in the following professions:

- Physician
- Dentist
- Veterinarian
- Optometrist
- Psychologist
- Nuclear Scientist
- Environmental Scientist
- Civil Engineer
- Podiatrist
- Audiologist
- Pharmacist
- Laboratory Scientist

As an Army Officer, you will receive substantial compensation, an annual paid vacation, and participate in a remarkable non-contributory retirement plan.

For more information just fill out the attached form and mail. Or call: (313) 668-2190/2191. (Collect calls accepted.)

PLEASE SEND MORE INFORMATION ABOUT OPPORTUNITIES
IN THE ARMY MEDICAL DEPARTMENT
MAIL OR CALL:
ARMY MEDICAL DEPT., PERSONNEL OFFICE, 200 E. LIBERTY ST.,
ANN ARBOR, MI 48107, PH: (313) 668-2190/2191

NAME ______________________ AGE _____
ADDRESS ______________________
ZIP ____________ PHONE (AC) ____________
SCHOOL ATTENDED/ATTENDING ____________
GRADUATION DATE ____________ DEGREE ____________
SPECIALTY AREA OF INTEREST ____________

AMA, MSMS MSMS/A and Medical Assistants

Sept. 19 — MSMS Board of Directors meeting, MSMS headquarters, contact: William Madigan, MSMS headquarters.

Oct. 9-10 — Women in Health Conference, sponsored by Center for Continuing Education, U-M School of Public Health, Michigan Department of Public Health and MSMS Committee on Concerns of Women Physicians, Dearborn Inn, contact: Linda Munson, MSMS headquarters.

Oct. 19-20 — Twelfth Annual Illinois Congress on Continuing Medical Education, Drake Oak Brook Hotel, Oak Brook, IL, contact: Illinois council on Continuing Medical Education, 55 E. Monroe St., Suite 3510, Chicago, 60603, 312-236-6110.

Oct. 25 —1984 MSMS Public Affairs/Leadership Conference, Long's Convention Center, Lansing, contact: Sherry Wellman, MSMS headquarters.

Nov. 13-15 — MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn, contact: Sherry Fent, MSMS headquarters.

Nov. 21 — MSMS Board of Directors meeting, MSMS headquarters, contact: William Madigan, MSMS headquarters.

Nov. 29-December 3 — Fourth Assembly Meeting of the AMA Hospital Medical Staff Section, Honolulu, Hawaii, contact: Bruce Ambrose, MSMS headquarters.

December 2-5 — Interim Meeting of AMA House of Delegates, Honolulu, Hawaii, contact: Bruce Ambrose, MSMS headquarters.

April 26-28, 1985 — 1985 MSMS House of Delegates meeting, Michigan Inn, Southfield, contact: Richard Campau, MSMS headquarters.

June 16-20, 1985 — Annual Meeting, AMA House of Delegates, Chicago, contact: Bruce Ambrose, MSMS headquarters.

Other meetings

September 19 — Chronic Illness in Children, University of Michigan, contact: John Hagen, MD, Bush Program in Child Development and Social Policy, 3415 Mason Hall, University of Michigan, Ann Arbor 48109-1027, (313) 764-2443 or 763-3717.

September 20-21 — Fourth Annual Meeting of Great Lakes Chapter of the Society for Public Health, Midway Motor Lodge, Lansing, contact: Katherine Jones, Vice President, GLC, SOPHE, Health Education Coordinator, St. Lawrence Hospital, 1210 W. Saginaw, Lansing 48915, (517) 377-0353.

September 21-23 — Fall Meeting, Michigan Society of Anesthesiologists, Amway Grand Plaza, contact: Caroline Rich, MSMS headquarters, East Lansing.

September 22 — Ophthalmology for the Family Practitioner, Michigan Osteopathic Medical Center, Detroit, contact: Medical Administration, Michigan Osteopathic Medical Center, 2700 Martin Luther King Jr. Blvd., Detroit 48208, (313) 361-8020.

September 25-26 — 17th Annual Great Lakes Cancer Nursing Conference, Lansing Hilton Inn, contact: American Cancer Society Michigan Division, Inc.

October 1 — "Death from a Child's Perspective," sponsored by Lansing Diocese, Catholic Church, and MSU Lifelong Education Programs at MSU Kellogg Center, East Lansing, contact: Betty Gaiss, OP, Diocese of Lansing.

October 3-4 — Fall House of Delegates Meeting of Michigan Hospital Association, Grand Traverse Resort, contact: Michigan Hospital Association, 6215 West St. Joseph Highway, Lansing 48917, (517) 323-3443.

October 12 — 1984 MDA Oral Cancer Symposium, Delta College University Center, contact: Jamie DePolo, Michigan Dental Association, 230 N. Washington Sq., Suite 208, Lansing 48933.

October 19 — 35th Anniversary Celebration of American Academy of Pediatrics, Grand Traverse Resort Village, contact: P. Miles Tiernan, Executive Secretary - MDAAP, 32245 Hearthstone, Farmington Hills 48108.

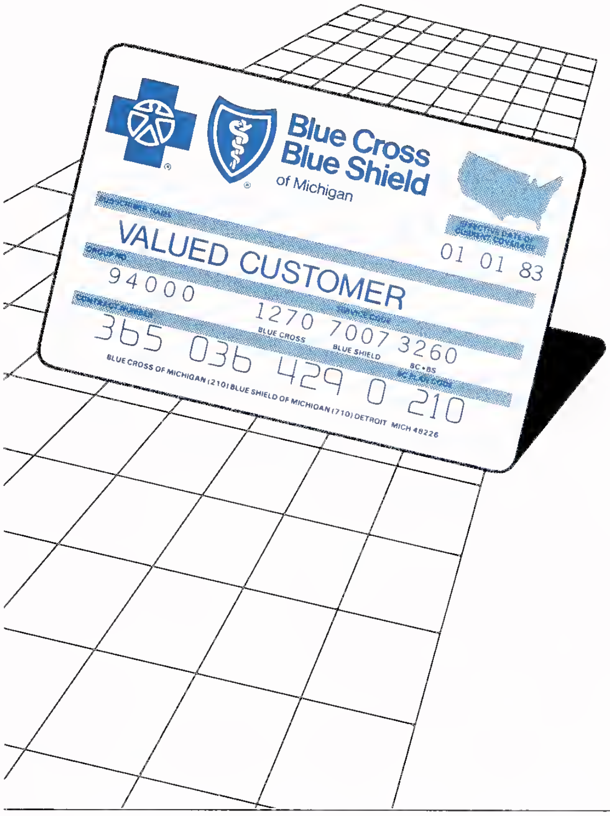
October 26 — Excellence in School Health, Sugar Loaf Resort, Traverse City, contact: Richard Murdock, Michigan School Health Association, P. O. Box 11129, Lansing 48901.

November 4 — Annual Meeting of Michigan Neurological Association, Botsford Inn, Farmington, contact: Raymond B. Bauer, MD, 4201 St. Antoine 6G, Detroit 48201 (313) 494-4281.

November 7-9 — Occupant Protection and Alcohol Countermeasures, Boyne Mountain, contact: Michigan Life Savers, Office of Highway Safety Planning, 111 S. Capitol, Lower Level, Lansing 48913.

DIMENSION III

LOW-COST HEALTH CARE COVERAGE FROM BLUE CROSS AND BLUE SHIELD OF MICHIGAN.



Blue Cross
Blue Shield
of Michigan
SUBSCRIBER NAME
VALUED CUSTOMER
EFFECTIVE DATE OF CURRENT COVERAGE
01 01 83
GROUP NO
94000
SERVICE CODE
1270 7007 3260
BLUE CROSS
BLUE SHIELD
BC+BS
BC PLAN CODE
CONTRACT NUMBER
365 036 429 0 210
BLUE CROSS OF MICHIGAN (210) BLUE SHIELD OF MICHIGAN (710) DETROIT MICH 48226

Now there's a new low-cost health care plan for Michigan State Medical Society members and their employees. It's Dimension III from Blue Cross and Blue Shield of Michigan... a health care plan in which the subscriber shares in the cost of the covered services. Dimension III is a lower cost alternative to the other health care plans presently available to doctors and their employees. Here's how the plan works.

Dimension III for doctors:
Deductible — $1,500 one person
$3,000 family

Dimension III for employees:
Deductible — $250 one person
$500 family

Once the deductible amount has been met, Dimension III pays 80% and the subscriber pays a 20% copayment for covered health care services. When the subscriber has paid $1,000 in copayments, no further copayments are required. Dimension III pays 100% up to $1 million. And when you select one of these plans, you'll get all the benefits that characterize the best health care coverage available:

☐ Hospital care benefits.
☐ Surgery.
☐ Maternity care.
☐ Outpatient care benefits.
☐ Psychiatric care benefits.
☐ The I.D. card that's recognized everywhere.
☐ A minimum amount of paperwork.
☐ A statewide network of Blue Cross and Blue Shield Service Centers to assist you and your employees.
☐ Worldwide coverage for you and your family.

Blue Cross and Blue Shield coverage is the choice of over 5 million Michigan residents. Why not make it your choice, too? For enrollment information, call your local Blue Cross and Blue Shield of Michigan representative.

CAN YOU AFFORD LESS?

Blue Cross
Blue Shield
of Michigan

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, (517) 337-1351.

Date: September 17-19, Current Concepts in the Management of Arrhythmias and Comary Heart Disease. Location: Towsley Center. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010, (313) 763-1400. **Approved for:** 20.5 hours of Category I Credit.

Date: September 19, New Perspecitves in the Treatment of Heart Failure. Location: Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit, 48202, (313) 876-3073. **Approved for:** 6 hours of Category I Credit.

Date: September 21-23, Tutorial on Myofascial Release Technique. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A306 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 24 hours of Category I Credit.

Date: September 24-25, New Approaches to Patient Care in Diabetes: Promoting Self-Care Behavior. Location: Towsley Center. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010, (313) 763-1400. **Appproved for:** 13.5 hours of Category I Credit.

Date: September 28, Basic Cardiac Life Support. Location: Towsley Center. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010, (313) 763-1400. **Approved for:** 6 hours of Category I Credit.

Date: September 29, You Could go to Court: Avoiding Legal Entanglements. Location: Towsley Center. Sponsor: University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor, 48109-0010, (313) 763-1400. **Approved for:** 6 hours of Category I Credit.

Date: September 29-30, Advanced Cardiac Life Support. Location: Towsley Center. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor, 48109-0010, (313) 763-1400. **Approved for:** 16 hours of Category I Credit.

Date: October 6-10, Advanced Muscle Energy Tutorial (above diaphragm). Location: Kellogg Center for Continuing Education, East Lansing, **Sponsor:** MSU Colleges of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilboum, A306 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

Date: October 11, Multiple Sclerosis: positive management. Location: Kalamazoo Hilton Inn. **Sponsor:** National Multiple Sclerosis Society, Michigan Chapter-South Central Branch, Borgess Medical Center and Western Michigan University Center for Human Services. **Contact:** Center for Human Services, Western Michigan University, Kalamazoo 49008. **Approved for:** 6 hours of Category I Credit.

Date: October 11-14, Michigan Regional Meeting of the American College of Physicians. Location: Boyne Highlands. **Sponsor:** American College of Physicians, Michigan Chapter. **Contact:** Arnold R. Axelrod, MD, FACP, Department of Medicine, Sinai Hospital, 6767 West Outer Drive, Detroit 48235, (313) 493-5780. **Approved for:** 20 hours of Category I Credit.

Date: October 12-13, Parenteral and Enteral Nutrition. Location: Towsley Center. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010, (313) 763-1400. **Approved for:** 9 hours of Category I Credit.

Date: October 17, Influencing Unfavorable Pregnancy Outcomes. Location: St. John Hospital. **Sponsor:** CME Committee of St. John Hospital. **For:** Interested physicians. **Cost:** $90.00. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road, Detroit 48236 (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: October 19, Basic Cardiac Life Support. Location: Towsley Center. **Contact:** Office of Continuing Medical Education, University of Michigan Medical School, Towsley Center, Box 057, Ann Arbor 48109-0010, (313) 763-1400. **Approved for:** 6 hours of Category I Credit.

Date: October 19-20, Cardiovascular Update '84: and the beat goes on. Location: Northfield Hilton, Troy. **Sponsor:** American Heart Association of Michigan and American Association of Critical Care Nurse. **Contact:** Eleanor D. Peterson, RN, American Heart Association of Michigan, P. O. Box 160, Lathrup Village, 48075. **Approved for:** 7.9 hours of Category I Credit.

Date: October 19-20, Digital Subtraction Angiography: 1984. Location: Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit, 48202, (313) 876-3073. **Approved for:** 14 hours of Category I Credit.

Date: October 19-21, American Academy of Pediatrics-Michigan Chapter, Scientific Program. Location: Grand Traverse Resort Complex. **Sponsor:** Michigan Chapter, American Academy of Pediatrics. **For:** Pediatrics, Family Practice, DO's and Health Providers for Children. **Contact:** P. Miles Tiernan, 32245 Hearthstone, Farmington Hills, 48018. **Approved for:** 7 hours of Category I Credit.

Date: October 23, Infectious Disease Update. Location: Towsley Center. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010, (313) 763-1400. **Approved for:** 6 hours of Category I Credit.

Date: October 24-25, New Solutions to Clinical Problems in Allergy. Location: Towsley Center. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010, (313) 763-1400. **Approved for:** 12.5 hours of Category I Credit.

Date: October 25-27, 15th Annual International Symposium on Impant Surgery for the Hand and Upper Extremity. Location: Blodgett Memorial Medical Center and Amway Grand Plaza Hotel, Grand Rapids. **Sponsor:** American Society for Surgery of the Hand. **Contact:** Alfred B. Swanson, MD, 290 Blodgett Professional Building, 1900 Wealthy Street, SE, Grand Rapids 49506 (616) 774-7294. **Approved for:** 19 hours of Category I Credit.

Date: October 25-27, 1984, Magnetic Resonance and Ultrasound Physics Continuing Education Course. Location: Towsly Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, Ann Arbor 48109, (313) 763-1400. **Approved for:** 6 hours of Category I Credit.

Date: October 26-28, Manual Medicine Principles Applied to the Extremeties. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilboum, A306 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 24 hours of Category I Credit.

continued on page 476

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android® /5 mg. Buccal/10 mg. Oral/25 mg. Oral
Methyltestosterone U.S.P. Tablets

ANDROID® /F
Fluoxymesterone U.S.P. Tablets, 10 mg.

CATEGORY I/continued

Date: October 27, Annual Meeting of Michigan Neurological Association. Location: Botsford Inn, Farmington. **Contact:** Raymond B. Bauer, MD, 4201 St. Antoine 6G, Detroit 48201 (313) 494-4281. **Approved for:** 4 hours of Category I Credit.

Date: November 3, Tenth Annual Symposium, "Child and Adult Analysis: Mutual Contributions." Sponsor: Michigan Psychoanalytic Society. **Contact:** Evangeline J. Spindler, MD, Chairman, 16310 West Twelve Mile Road, Suite 204, Southfield, 48076, (313)557-8633. **Approved for:** 3 hours of Category I Credit.

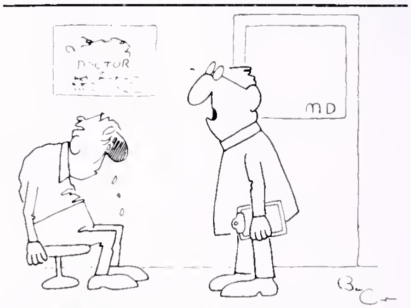
Date: November 8-10, Laser Bronshoscopy, A Practical Course with Hands-on Experience. Location: Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit, 48202, (313) 876-3073. **Approved for:** 14 hours of Category I Credit.

Date: November 14, Alcoholism. Location: St. John Hospital. **Sponsor:** CME Committee of St. John Hospital. **For:** Interested physicians. **Cost:** $90.00. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road, Detroit 48236 (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

November 18, Eighth Annual Pediatrics Seminar. Location: Kellogg Center for Continuing Education. **Sponsor:** Michigan State University College of Osteopathic Medicine's Department of Pediatrics. **Contact:** Sandy Kilbourn, A306 E. Fee, MSU-COM, East Lansing 48824, (517) 353-9714. **Approved for:** 6 1/2 hours of Category I Credit.

Date: December 3-7, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine and North American Academy of Manipulative Medicine. **Contact:** Sandy Kilbourn, A306 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

Date: January 12, 1985, Primary Care Medicine: An Exciting Frontier Revisited. Location: Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit, 48202, (313) 876-3073. **Approved for:** 16 hours of Category I Credit.



"You are terribly sick. You should be in bed. What are you doing here?"

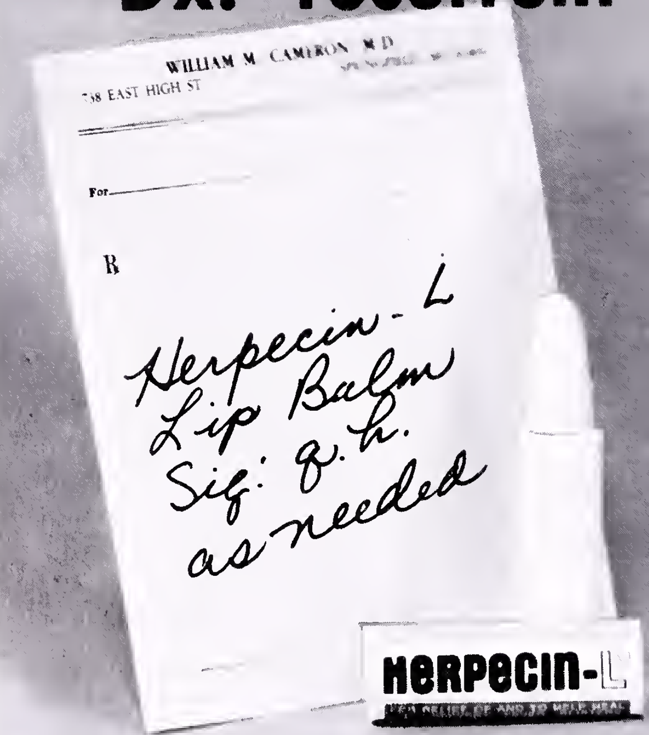
Date: February 4-6, 1985, Hemodynamic Monitoring VII. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, Ann Arbor 48109 (313) 763-1400. **Approved for:** 14.5 hours of Category I Credit.

Date: February 27, 1985, Cardiology-Update. Location: St. John Hospital. **Sponsor:** CME Committee of St. John Hospital. **For:** Interested physicians. **Cost:** $90.00. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road, Detroit 48236 (313) 343-3877 **Approved** for: 8 hours of Category I Credit.

Date: April 10, 1985, Primary Care Medicine: An Exciting Frontier Revisited. Location: Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit, 48202, (313) 876-3073. **Approved for:** 16 hours of Category I Credit.

Date: May 6-8, 1985, Hemodynamic Monitoring VIII. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, University of Michigan, Ann Arbor 48109 (313) 763-1400. **Approved for:** 14.5 hours of Category I Credit.

Dx: recurrent herpes labialis



"Herpecin-L Lip Balm is **the treatment of choice** for peri-oral *herpes.*" GP, New York

"In the management of *herpes labialis,* Herpecin-L is a **conservative approach** with **low risk / high benefit.**" Derm., Miami

"Staff and patients find Herpecin-L remarkably **effective.**" Derm., New Orleans

OTC. See *P.D.R.* for information.
For trade packages to make your own clinical evaluation, write:
CAMPBELL LABORATORIES INC.
P.O. Box 812-M, FDR, NY, NY 10150

In Michigan, "HERPECIN-L" Cold Sore Lip Balm is available at all *Muir, Perry, Revco* and *Sentry Drug Stores* and other select pharmacies.

Motrin®
ibuprofen, Upjohn
600 mg Tablets

MOTRIN 600mg

More convenient for your patients.

Upjohn

© 1984 The Upjohn Company

The Upjohn Company • Kalamazoo, Michigan 49001 USA

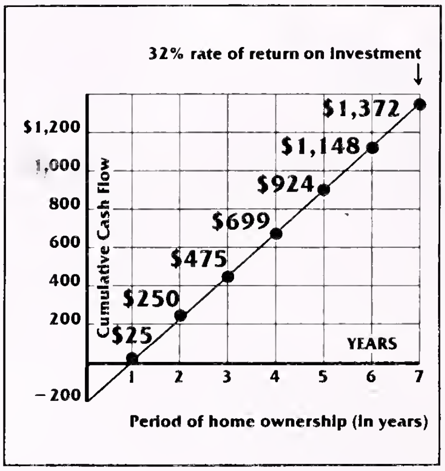
J-4044 January 1984

WHAT CAN GIVE YOU A BETTER RETURN THAN A C.D., MONEY MARKET OR SAVINGS ACCOUNT?

Believe it or not, it's your own home. Investing in energy-saving improvements in your home can help you save money *and* make money. It's one of the best investment choices you can make—even better than a C.D., money market or savings account.

How is energy efficiency profitable?

Owning an energy efficient house can make you money. Conservation features can more than pay for themselves through reduced energy costs, giving you a handsome rate of return on your initial investment. And the money you save on energy is *tax-free*. The same holds true when you buy an energy efficient house. The graph (right) illustrates the potential return on investing an additional $200 down payment in a house with $1,000 worth of energy-saving features.



For more details on these and other conservation investment tips, write the Alliance to Save Energy. Return the coupon below and you'll receive *Your Home Energy Portfolio*, a comprehensive guide to conservation investment opportunities in your own home. If you're looking for a great investment, there's no place like home.

Please send my free copy of *Your Home Energy Portfolio*.

Name________________________________

Address______________________________

City________________ State________ Zip________

Mail to: Alliance to Save Energy, P.O. Box
57200, Washington, DC 20037

ALLIANCE TO SAVE ENERGY

Ad Council *A public service message from this magazine and the Advertising Council.*
Also sponsored by: Federal Home Loan Mortgage Corporation, Federal National Mortgage Association, National Institute of Building Sciences, U.S. Department of Energy.

Forrest J. Arnoldi, MD
Allen Park

Forrest J. Arnoldi, MD, Allen Park, died on June 26, at the age of 50. Doctor Arnoldi graduated from Wayne State Medical School in 1959. He served his internship at Harper Hospital and followed with his residency in radiology at the same hospital. Doctor Arnoldi served on the staff of Harper Hospital in the radiology department.

Leonard C. Blakey, MD
Monroe

Leonard C. Blakey, MD, Monroe, died on June 11. He was 85. Doctor Blakey graduated from Queen's Medical University in Kingston, Ontario in 1922. Doctor Blakey retired in 1977 after more than 50 years as a general surgeon in the Monroe area. Doctor Blakey was honored on his 80th birthday with a "Doctor Leonard C. Blakey Day" in recognition of the years of service he gave to the Monroe community.

William G. Coleman, MD
Detroit

William G. Coleman, MD, Detroit, died on June 30 at the age of 82. Doctor Coleman graduated from Western University in London, Ontario in 1929 and came to Detroit in 1939. He was on the Mt. Carmel staff until he retired in 1983. Doctor Coleman was a member of Detroit Commandery No. 1, Knights Templar.

George L. Gundry, MD
Grand Blanc

George L. Gundry, MD, Grand Blanc, died on June 7. He was 93. Doctor Gundry graduated from Loyola University's Medical School and returned to Grand Blanc to practice medicine as the town's first doctor. He was proud of having delivered over 6,000 babies and was regarded as one of Genesee County's most respected physicians.

Paul W. Kniskern, MD
Grand Rapids

Paul W. Kniskern, MD, Grand Rapids, died on June 30 at the age of 81. He graduated from the University of Michigan Medical School in 1927. Doctor Kniskern held the positions of city physician of Grand Rapids and then medical director of the Kent County Welfare Department until 1935 when he re-entered private practice. After serving in World War II, he returned to general practice and his office in Grand Rapids. Doctor Kniskern retired from active medical practice in 1980.

Paul C. Turner, MD
Lansing

Paul C. Turner, MD, Lansing, died on July 18. He was 53. Doctor Turner graduated from the University of Michigan Medical School. He did his residency at Henry Ford hospital. Doctor Turner was the medical director of the Detroit Industry Clinic in Lansing.

Prepare For:

- **TOEFL**
- **MSKP**
- **NATIONAL MEDICAL BDS**
- **VQE**
- **ECFMG**
- **FLEX**
- **DENTAL BDS**
- **PODIATRY BDS**
- **NURSING BDS**

- Voluminous home study notes on all areas of basic science.
- Teaching tests accompanied by comprehensive teaching tapes to be used at any of our tape centers.
- Materials constantly updated.
- Over 40 years of experience and success in the field of test preparation.

Stanley H. KAPLAN EDUCATIONAL CENTER

For information Please Call:
Ann Arbor (313) 662-3149
Detroit (313) 569-5320
E. Lansing (517) 332-2539
Centers in More than 115 Major U.S. Cities. Puerto Rico and Toronto, Canada

PRACTICES FOR SALE

MEDICAL PRACTICE — Allen Park area. Good equipment and great location. Call for more information today!

INTERNAL MEDICINE — Hospital-based practice with net income of $200,000. Plenty of good equipment.

FAMILY PRACTICE — St. Clair Shores area. Well-established. Has rental income, fantastic terms and a lab connection. **GREAT EARNINGS!**

FAMILY PRACTICE—Redford area Excellent equipment and office furniture. Well-established practice. Building and rental included.

MEDICAL PRACTICE—Lansing area Industrial and family, good equipment. Also, building is optional. **Great Opportunity**.

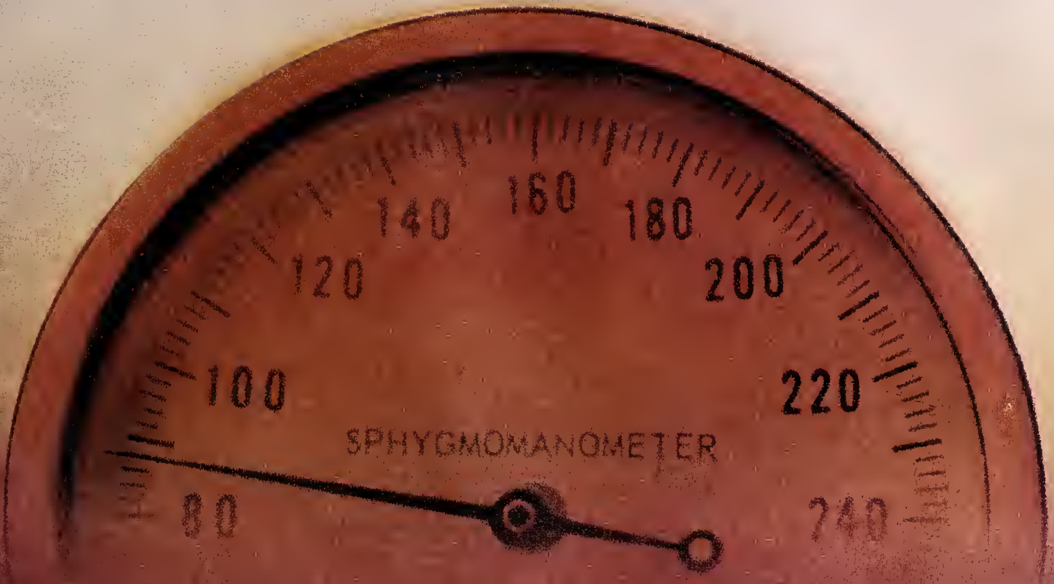
Professional Practice Sales, Inc.
27208 Southfield Road
Lathrup Village, Michigan 48076
HERBERT SILVERMAN, BROKER
(313) 569-7336

Just once each day...

First-step blood pressure control with optimal simplicity

Benefits diuretics cannot offer... Once-daily INDERAL LA (propranolol hydrochloride) with its smooth 24-hour control of blood pressure provides a high degree of patient acceptance without potassium problems, plus the cardiovascular benefits of the world's leading beta blocker.

Experience no other beta blocker can match... Once-daily INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.


140
160
180
120
200
100
220
SPHYGMOMANOMETER
80
240

Start with 80 mg once daily. . . Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY
INDERAL® LA
(PROPRANOLOL HCl) LONG ACTING CAPSULES
Just once each day for initial therapy in hypertension.

AL LA
AL LA
AL LA
80 mg
120 mg
160 mg

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

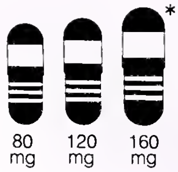
Ayerst

Just once each day for initial therapy in HYPERTENSION.

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) *LONG ACTING CAPSULES*



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic INDERAL LA is not indicated in the management of hypertensive emergencies

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL

WARNINGS. CARDIAC FAILURE Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

> IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers

DIABETES AND HYPOGLYCEMIA Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin

THYROTOXICOSIS Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker In one case this resulted after an initial dose of 5 mg propranolol

PRECAUTIONS. *General.* Propranolol should be used with caution in patients with impaired hepatic or renal function INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure Patients should be told that INDERAL may interfere with the glaucoma screening test Withdrawal may lead to a return of increased intraocular pressure

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug

Pregnancy Pregnancy Category C INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use. Safety and effectiveness in children have not been established

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances; hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics

Gastrointestinal nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory bronchospasm

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura

Auto-Immune. In extremely rare instances, systemic lupus erythematosus has been reported

Miscellaneous. alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved The usual maintenance dosage is 120 to 160 mg once daily In some instances a dosage of 640 mg may be required The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks

ANGINA PECTORIS—*Dosage must be individualized* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS)

MIGRAINE—*Dosage must be individualized* The initial oral dose is 80 mg INDERAL LA once daily The usual effective dose range is 160-240 mg once daily The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued It may be advisable to withdraw the drug gradually over a period of several weeks

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories

8950/284

Just once each day...

Ayerst® AYERST LABORATORIES
New York, N.Y. 10017

This publication is available in microform.

University Microfilms

University Microfilms International

Please send additional information for ______________________________
(name of publication)

Name ______________________________

Institution ______________________________

Street ______________________________

City ______________________________

State ____________ Zip ______________

300 North Zeeb Road
Dept. P.R.
Ann Arbor, Mi. 48106
U.S.A.

30-32 Mortimer Street
Dept. P.R.
London W1N 7RA
England

Clinical Scientist Central Nervous System Research Ann Arbor, Michigan

The Warner-Lambert/Parke-Davis Pharmaceutical Research Division is seeking an outstanding, innovative clinical scientist for a highly responsible position in our Clinical Research Department.

The successful candidate for the position of Assistant Director, Clinical Science, will plan, implement, and monitor the clinical studies of important new CNS therapeutic programs; will provide scientific interpretation and summarization of clinical and/or pre-clinical data and participate in the preparation and presentation of the New Drug Application.

The requirements for this position include either an M.D. or Ph.D. degree in a life science related to drug development, and 8 to 10 years pharmaceutical research experience in clinical or preclinical areas with particular emphasis in neurological science. He/she must demonstrate management skills and strong colleagueal relationships with key neurological clinical investigators. Excellent oral and written communication skills are required.

The Warner-Lambert/Parke-Davis research facilities, adjoining the University of Michigan campus in Ann Arbor, Michigan are among the finest and best equipped in the world and are dedicated exclusively to the discovery and development of new drugs.

Join the exciting Research and Development team of this dynamic, expanding organization and enjoy an outstanding compensation plan and environment. Qualified applicants should send a resume and salary requirements in confidence to: Ms. M. Wolin, Senior Human Resources Representative, WARNER-LAMBERT/PARKE-DAVIS, Dept. 2584, 2800 Plymouth Road, Ann Arbor, MI 48105
An Equal Opportunity Employer M/F/H.

WARNER
LAMBERT

The rate for each classified advertisement in *Michigan Medicine* is 20¢ per word, with a minimum charge of $10.00. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

POSITIONS OPEN

PSYCHIATRIST: FULL TIME private or multi-specialty group practice in Upper Peninsula of Michigan. Rural University Community. Significant mental health support. Send CV to D. Murphy, 821 Water Street, Hancock 49930.

PROGRAM DIRECTOR FOR DEPARTMENT OF MEDICINE, St. Joseph Mercy Hospital, Pontiac, Michigan — Candidate should be board certified in internal medicine and have a commitment to research, clinical service and medical education and be able to administer an academic program. This 531-bed hospital is part of the Sisters of Mercy Health Corporation. Forward vitae to: Kenneth Urwiller, MD, Vice President of Medical Services, St. Joseph Mercy Hospital, 900 Woodward Ave., Pontiac 48053. An equal opportunity employer.

WANTED - A PSYCHIATRIST to join a busy practice of General Psychiatry. Excellent salary and fringe benefits. Reply to Box 65, Michigan Medicine, 120 W. Saginaw, East Lansing 48823.

WANTED: YOUNG OB/GYN PHYSICIAN. Grad of United States school, to associate with Ob/Gyn. Must be willing to live and practice in Northeast suburbs. Guaranteed income. Please call (313) 463-2020.

KALAMAZOO, MICHIGAN - EXPERIENCED PHYSICIAN needed to work with eight other clinicians in the University Health Center. Malpractice coverage and excellent fringe benefits. Beautiful clinic on campus in well located civic minded city. Salary negotiable. Position open September 1, 1984. Contact: Donald T. McNally, Director, University Health Center, Western Michigan University, Kalamazoo 49008. Call collect: (616) 383-6003. Western Michigan University is an EEO/AA employer. Women and minorities are encouraged to apply.

GENERAL SURGEON - Board certified or board eligible. To join eight member family practice medical center. Have full-time radiologist. Major specialties consult on regular basis. Located at International Falls in northern Minnesota. Near Voyageurs National Park. Year around outdoor recreation abounds. Served by major airline. Population twenty thousand. Send curriculum vitae to Doctor James R. Schuft, Falls Medical Center, Shorewood Drive, International Falls, Minnesota 56649.

SUBURBAN ESTABLISHED INTERNAL MEDICINE PRACTICE-close to East Michigan industrial area and Major Medical Centers. Ideal for woman physician. Available in fall. Will assist in take over. Terms negotiable. Send resume to Box 63, Michigan Medicine, 120 W. Saginaw, East Lansing 48823.

FAMILY PHYSICIAN NEEDED TO JOIN THREE active, Board Certified Family Physicians in a beautiful, mid-size city on Lake Michigan. Full hospital staff privileges are available, including obstetrics. Call: J. Jarvis (616) 733-3177, or write: 1223 Mercy Drive, Muskegon, 49444.

RESEARCH ASSOCIATE IN INTERNAL MEDICINE wanted to conduct research on adult hypertensive and diabetic patients in an urban location; analyze the efficacy of various classes of antihypertensive medications; study the effectiveness of various oral hypoglycemic agents on diabetic patients; study the relationship between the complications of diabetes mellitus in relation to the duration of the disease; analyze data and prepare results for publication. Requires MD degree and one year training as a Resident in Internal Medicine; 40 hours per week; $16,000.00 per year. Send resume to 7310 Woodward Ave., Room 415, Detroit, 48202. Ref. No. 22984.

FAMILY PRACTITIONER - Seeking associate, board certified or eligible, to join a well established Family Practice Clinic with x-ray and laboratory facilities. Excellent opportunity to be part of an expanding practice located in a water recreational area northeast of Detroit. Call (313) 794-9331 ask for Barbara, or write c/o Box 406, Algnoac.

MEDICAL DIRECTOR. OPPORTUNITY FOR PHYSICIAN with experience in medical group practice administration to join established HMO in Madison, Wisconsin. Group Health serves 29,000 patients with its staff of 20 physicians and total staff of 180. Excellent salary and benefit program. This represents a rewarding opportunity to develop or progress your career in medical administration. Contact: John Mueller, Group Health Cooperative, 1 South Park St, Madison, WI 53715; (608) 251-4156.

FAMILY PRACTICE. RAPIDLY EXPANDING STAFF MODEL HMO in Madison, Wisconsin, has opportunities for additional family practice physicians. Competitive salary with excellent benefits and attractive practice setting. GHC is an established, rapidly growing HMO serving 29,000 patients. Current staff totals 180 employees, including 20 physicians. Contact: John Mueller, Group Health Cooperative, 1 South Park St, Madison, WI 53715; (608) 251-4156.

OB/GYN. GROUP HEALTH COOPERATIVE has 1984 opening for Board certified/eligible obstetrician and gynecologist. GHC is an established, rapidly expanding HMO. Staff enjoy a stable salary plus excellent benefit program including 5-6 weeks of time off plus $3,000 CME funding. Madison is a city of 200,000 population; University of Wisconsin; and 4 lakes. Contact: John Mueller, Group Health Cooperative, 1 South Park St, Madison, WI 53715; (608) 251-4156.

FAMILY PRACTITIONERS, GENERAL PRACTITIONERS or Emergency Medicine Physicians with practice experience wanted for free-standing urgent care centers located in the Central Michigan area. Excellent access to recreational areas. Associate and Medical Director opening immediately. Other vacancies opening in August or September of 1984. Salary negotiable plus fringe benefits. Send C.V. to Contemporary Medical Management, Incorporated, 401 South Euclid Avenue, Bay City 48706 (517) 667-0494.

GENERAL SURGEON, BOARD CERTIFIED or eligible, to join seven doctor family practice Clinic in Cloquet, Minnesota, a community of 12,000 (30,000 service area) located 20 minutes from Duluth-Superior. Clinic facility is located one block from modern, well equipped 77 bed hospital. Cloquet enjoys a stable economy (forest products). Additionally, our community is noted for its excellent school system. First year salary guarantee, paid malpractice, health and disability insurance, vacation and study time. Contact John Turonie, Administrator, Raiter Clinic, Ltd., 417 Skyline Blvd., Cloquet, MN 55720. Telephone (218) 879-1271.

POSITIONS WITH THE STATE OF MICHIGAN — Currently taking applications for positions expected to be available in the future. Office locations now include Kalamazoo, Lansing, Southfield, and Traverse City. A board certified or board eligible psychiatrist needed for the Kalamazoo office, and internists with rheumatology or cardiology background desired for other offices. Beginning salary in low 60's with approximately 26% fringe benefits. An equal opportunity employer. All inquiries treated confidentially. For further details, please write: Harry D. Nesmith, MD, Chief Medical Consultant, Disability Determination Service, PO Box 30011 Lansing, 48909.

FAMILY PHYSICIAN: IMMEDIATE OPENING for a residency trained FP preferring small-town life style and interested in "whole person medicine from the Christian perspective" in a new office in the small college town of Hillsdale in southern Michigan. Write or call: Frederick L. Bean, MD, Hillsdale Family Practice, 111 South Howell, Hillsdale, 49242.

POSITIONS WANTED

PHYSICIAN WISHES TO ACQUIRE busy family practice in Detroit suburb or southeast Michigan. Reply Box 64, Michigan Medicine, 120 W. Saginaw, East Lansing 48823.

MISCELLANEOUS

BURT LAKE - AN ENCLOSED 40′ swimming pool, stunning sunsets, and the sandy beaches are among the enticements of this beautiful custom-built Burt Lake home located at the mouth of the Sturgeon River. A 40′ living area with a cut-stone fireplace and a wall of windows provide a breath taking view of the sparkling waters of Burt Lake. The home is completely furnished and equipped consisting of 3 bedrooms, 3 ceramic baths, and nice modern kitchen. There is an attached pine paneled garage with a walk-in cooler. Excellent fishing, water skiing, boating and swimming are right out the front door. A.K. Smith and Son Real Estate; Box 430, Indian River, (616) 238-9338.

PHYSICIAN OPPORTUNITIES. Bernie Hoffmann Associates, Inc. is currently assisting a major metropolitan Detroit health care provider in the expansion of their suburban clinic network. The search for qualified physicians includes the following specialties: Obstetrics and Gynecology, Emergency Medicine, Family Practice, Internal Medicine, Orthopedic Surgery and Pediatrics. The typical satellite center provides an excellent practice setting for a four person physician group. There are over 30 opportunities for board eligible or board certified physicians with available starting dates of 10/1/84, 1/1/85, and 7/1/85. A compensation program emphasizing flexibility and incentive will be explored with invited candidates. Interested physicians should submit curriculum vitae in confidence to: Tim Ignash, Senior Associate, Bernie Hoffmann Associates, Inc., One Northland Plaza, 20755 Greenfield, Suite 601, Southfield 48075, (313) 557-9340.

MICHIGAN: PRACTICE OPPORTUNITIES NOW AVAILABLE. Immediate income from well established practice, malpractice insurance, fully equipped office, with a congenial staff. Excellent opportunity for ambitious physician. For more information contact: Emergency Consultants, Inc., One Windemere Place, Petoskey 49770; 1-800-253-7092 or in Michign 1-800-632-9650.

MICHIGAN: EMERGENCY CONSULTANTS, INC. currently staffs emergency departments throughout the state. Full-time and part-time positions available in rural and urban locations. Guaranteed hourly rate plus malpractice insurance. Contact Emergency Consultants, Inc., 2240 S. Airport Rd., Suite 115, Traverse City 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

FOR LEASE. PRIME, NEW PROFESSIONAL office space in the Union Lake-West Bloomfield area, Oakland County. New Professional office building in what will be the place to go for health care. A place with identity. Growing area, with solid base of older homes. One of the best locations in the Tri County area. Ideal area for specialists of any kind as they are needed. Custom designed suites from 800 to 6000 square feet. Great place to live. For information call (313) 363-0365 or 625-0660.

DETROIT DOWNRIVER AREA physicians wish to acquire or organize a Home Health Care Agency. Joint venture possible. Reply to Box 64, Michigan Medicine, 120 W.Saginaw, East Lansing 48823.

ESTABLISHED MEDICAL PRACTICES FOR SALE. All active. Practices are located in the following areas: Detroit, Roseville and Rochester. Please call Commonwealth Real Estate Group (313) 288-0022. Ask for Lydia Sikora.

FOR SALE: MEDICAL PRACTICE in North Oakland County. Sale Price: $34,000. Call Commonwealth Real Estate Group, Inc. (313) 288-0022.

INCOME PRODUCING INVESTMENT FOR SALE. Prestigous 18,000 sq. ft. office building, fully leased. Near 11 Mile and Lahser. $725,000. Terms: L/C 9% Interest. Call Commonwealth Real Estate Group (313) 288-0022.

WE HAVE QUALIFIED PURCHASERS looking to purchase Nursing Homes in Michigan. All inquiries confidential. Call Commonwealth Real Estate Group (313) 288-0022.

PRACTICES WANTED. We have qualified purchasers looking to assume established MD, DO and DDS practices in Metro area. All inquiries confidential. Call Commonwealth Real Estate Group (313) 288-0022.

GOOSE AND PHESANT HUNTING. Private lodge, exclusive hunting on 800 acres. Gourmet meals. Lodging and guide service. Exclusive use with individual parties of 4-6 hunters. Total privacy for both business entertaining or for the sportsman in need of a quality hunt with friends. Reservations required. Brace Creek Lodge, 19425 Homer Road, Marshall 49068, (616) 781-7116 (Marshall), (517) 349-4251 (Okemos).

RENTAL - NORTHERN MICHIGANS HISTORIC HORTON BAY. Enjoy your vacation in an authentic Hemingway location. Shangri-la is a recently renovated cottage providing luxury accomodations overlooking beautiful Lake Charlevoix. Seven bedrooms, 3 1/2 baths, large deck, fireplace, modern fully equipped kitchen. Ideal for golf, color tour, skiing or family groups. $750.00/week, $175.00/day, $175.00 security deposit. No pets. Inquire about off season rates. Call (616) 547-5124 or write Shangri-la Properties, 303 Central, Charlevoix, 49720.

IF YOUR TAX SHELTER HAS COLLAPSED and you are faced with recapture and/or other tax burdens, there may be viable solutions to the problem. When you participated in the tax shelter, you were probably too busy in your own practice to analyze it and relied on opinions of others. With a minimal amount of your time, you may turn this problem over to Liberson and Bock, P.C., attorneys, to analyze the possibility of recovery of your losses from responsible third persons. Liberson and Bock, P.C., attorneys at law, (313) 358-3010.

FOR SALE. MARCO ISLAND CONDOMINIUM, high-rise, on the beach. Beautiful Gulf of Mexico view and island view. Two bedroom - two and one-half baths- approximately 2000 square feet. All amenities. For the discriminating buyer. Decorator furnished. Call area (313) 651-3871.

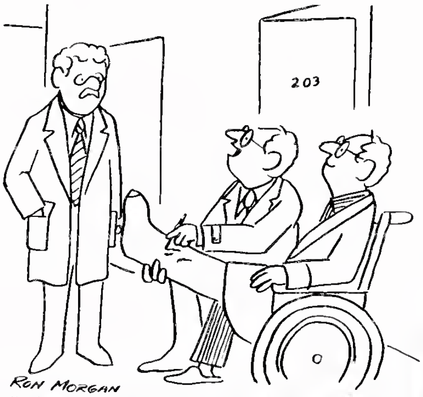
DOCTOR, YOU CAN'T BEAT THE QUALITY OR THE PRICE! Holter Monitor scanning service. Physician owned, trained and supervised. $35.00 for cassette reports: $45.00 for reel to reel reports; No contracts to sign. We can arrange for lease/purchase of holter equipment. Why are you paying more and getting less? DCG Interpretation (313) 879-8860.

ATTENTION DOCTORS: We have previously owned medical, laboratory, office and x-ray equipment in excellent condition. We buy, sell, broker and repair. Office appraisals available by certified surgical consultants. Call Doctor Medical Resale at (313) 569-4407 9 AM - 9 PM.

PHYSICIAN SIGNATURE LOANS TO $50,000. Up to 7 years to repay. No repayment penalties. Prompt, courteous service. Competitive fixed rate, with no points, fees or charges of any kind. Physicians Service Association, Atlanta, GA. Toll-free (800) 241-6905.

Thanks to our advertisers

AMRC	457
Ad Council	478
American Physicians Life	465
Ayerst	436-438 & 461-462, 480-481-482
Bennethum Computer Systems	456
Blue Cross/Blue Shield	473
Brown Pharmaceutical	475
Campbell Labs	476
Coamerica	455
HASCO	445
Havenwyck Hospital	451
Stanley H. Kaplan	479
Lab of Clinical Medicine	470
Life of Virginia	452-453
Eli Lilly	443
MPMLC	446-447
MSMS ASM Meeting	IFC
Marion Laboratories	467-468
Medical Protective	466
PICOM	441
Postgraduate Medicine	466
Professional Practice Sales	479
Roche Laboratories	IBC-BC
Stratton-Cheeseman	459
US Army	471
Union Bank & Trust	449
Upjohn Company	477
Warner Lambert	483
Woodside Capital	448



"I know he's not my patient. But everyone wants my autograph since my book made the best seller list."

Digest of Proceedings, Michigan Board of Medicine

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are summarized below by MSMS legal counsel from official memoranda to MSMS.

Name: Zenaida I. Lagman, MD
Action, Date Taken: License revoked, June 20, 1984
Reason: Negligent and failed to exercise due care in the supervision of her employees. Prescribed amphetamines for weight reduction without first ascertaining the need for such action. Prescribed habit-forming drugs without determining the individual had a drug abuse problem.

Name: Timothy Rudolph, MD
Action, Date Taken: License revoked and fined $1,000, June 20, 1984
Reason: Was convicted of conspiracy to distribute controlled substances, unlawful distribution of controlled substances and aiding and abetting. Disciplinary action resulting from a conviction related to his practice of medicine.

Name: Isaac Schaver, MD
Action, Date Taken: License revoked, June 20, 1984
Reason: Respondent prescribed Demerol for his personal use and acknowledged his addiction; engaging in substance abuse, obtained controlled substance for other than legitimate purposes and suffers a mental or physical inability related to his ability to practice.

David R. Rovner, MD

You're invited to Scientific Meeting!

MSMS President Louis R. Zako, MD, has given this month's page to the chairman of the 1984 MSMS Annual Scientific Meeting, David R. Rovner, MD, East Lansing. Doctor Rovner, professor, Department of Medicine, and chief, Department of Endocrinology and Metabolism, Michigan State University College of Human Medicine, presents a special message on the meeting.

I am pleased to take this space to invite my colleagues to the 1984 MSMS Annual Scientific Meeting. The dates are Nov. 13, 14 and 15 and the place again is the excellent Hyatt Regency Dearborn.

Our meeting, one of the largest CME presentations of a state medical society in the country, provides much for specialist and generalist, and brings us all up to date on the latest developments in medicine.

Artful medicine

Throughout our plans for this meeting, the committee and I have sought to help physicians improve the art of their calling. Thus, the promotional theme, "The Art of Medicine," illustrated on the cover of this issue, on advertisements inside and on all mailings to prospective attendees.

This theme ties in with MSMS President Zako's call to all Michigan physicians expressed in his installation address in May and throughout his appearances as head of our 10,000 member organization. He asks us to improve the art of our medicine, as well as our technology, through a renewed commitment to the patient.

Doctor Rovner

Michigan physicians may earn up to 18 hours of Category I CME credit attending the ASM. Its 55 half-day courses each grant three hours of credit to attendees.

MSMS Annual Scientific Meeting fees are low ($6 per credit hour for MSMS members, $12 per credit hour for non-members, $5 per course for resident physicians and $3 per credit hour for retired MSMS members). Thus our meeting, at $108 maximum cost for a member, is an economical way to meet the state's relicensure requirements.

In addition to being economical, the meeting is located at the very accessible Hyatt Regency in Dearborn, with its easy parking and electronic "people-mover" connections to the Fairlane shopping and entertainment center. Around the corner are two of our country's major tourist attractions — Greenfield Village and the Henry Ford Museum.

As the Annual Scientific Meeting Planning Committee and I made arrangements for this year's meeting, we put greater emphasis on our offerings for surgeons, in order to attract larger numbers of this important group. You will find courses with surgical topics throughout the program elsewhere in this issue.

Another group we gave greater attention to is our younger physicians. For them, we have planned for the first time the opportunity to present poster displays in areas of their expertise. So attractive has this offering proved in its first year that we have had to limit the number participating. We simply do not have space for more.

Again this year we will have 70 excellent educational and commercial medical firms exhibiting in the hall of the Hyatt Regency. Their booths provide more learning and hands-on experiences for the attending physician, as well as a place to meet with the day's speakers over coffee or beer.

As you read this brief message today, I hope you will feel personally invited to attend this major educational event, planned by MSMS and specifically the Annual Scientific Meeting Committee, with your needs and goals in mind.

This is my second and last year as chairman of the meeting, and I can tell you that you have a dedicated, earnest, and enthusiastic group working to meet your needs as they plan the Annual Scientific Meeting.

Wonderful group

It has been a pleasure for me serving with this wonderful group, and I look forward to continuing my association with them in years ahead, to assure that MSMS educational offerings are truly worthwhile for MSMS members.

I would like to list them all here, and give them my hearty thank you.

Frederick W. Bryant, MD, Royal Oak
Denis F. Cash, MD, Flint
Edward Cotton, MD, Marcellus
Dorothy Kahkonen, MD, Detroit
Kenneth L. Krabbenhoft, MD, Detroit
Joan C. Stryker, MD, Detroit
Herbert A. Auer, East Lansing, consultant
Sherry L. Fent, MSMS staff

COMPLETE LABORATORY DOCUMENTATION[1-5]... EXTENSIVE CLINICAL PROOF

FOR THE PREDICTABILITY
CONFIRMED BY EXPERIENCE

DALMANE® Ⓒ
flurazepam HCl/Roche

THE COMPLETE HYPNOTIC
PROVIDES ALL THESE BENEFITS:

- Rapid sleep onset[1-6]
- More total sleep time[1-6]
- Undiminished efficacy for at least 28 consecutive nights[2-4]
- Patients usually awake rested and refreshed[7-9]
- Avoids causing early awakenings or rebound insomnia after discontinuation of therapy[2,5,10-12]

Caution patients about driving, operating hazardous machinery or drinking alcohol during therapy. Limit dose to 15 mg in elderly or debilitated patients. Contraindicated during pregnancy.

DALMANE® Ⓒ
flurazepam HCl/Roche

References: **1.** Kales J *et al*: *Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A *et al*: *Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A *et al*: *Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A *et al*: *Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol 3*:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. 9. Amrein R *et al*: *Drugs Exp Clin Res 9*(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol 3*:303-326, May 1981. **11.** Greenblatt DJ *et al*: *Sleep 5*(Suppl 1):S18-S27, 1982. **12.** Kales A *et al*: *Pharmacology 26*:121-137, 1983.

DALMANE® Ⓒ
flurazepam HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

DOCUMENTED
IN THE SLEEP
LABORATORY[1-5]...

PROVEN IN
THE PATIENT'S
HOME

FOR A COMPLETE NIGHT'S SLEEP

DALMANE® ⓘⓥ

flurazepam HCl/Roche

STANDS APART

15-MG/30-MG CAPSULES

See preceding page for references and summary of product information.

Copyright © 1984 by Roche Products Inc. All rights reserved.

STACKS

MICHIGAN MEDICINE

October 1984 The award-winning JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Vol. 83, No. 46

M. D. S.
Levin
MONDALE
FERRARO
Wolpe
Our Congres
JACK
LOUSMA
SENATE.
THE JOB SHOP
REAGAN-BUSH '84
Paid for by Reagan-Bush '84

225 0000000000 123184
SERIALS DEPT - LIBRARY
COLLEGE OF PHYS OF PHILA
19 SOUTH 22ND STREET
PHILADELPHIA, PA 19103

Getting out the physician vote

LIBRARY
THE
COLLEGE OF PHYSICIANS
OF
OCT 25 1984

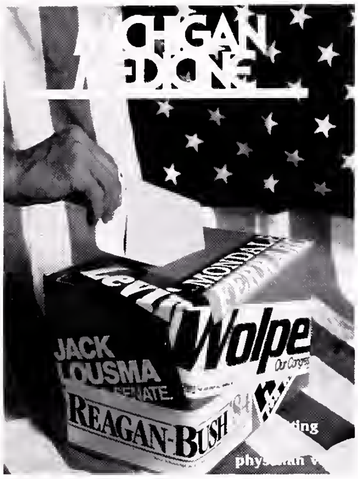
The Art of Medicine

The 1984 MSMS Annual Scientific Meeting focuses on the artful practice of medicine. You can choose from 55 CME courses on many clinical topics and earn up to 18 hours of Category I Credit. Come, let MSMS help you enhance your "art."

1984 MSMS ANNUAL
SCIENTIFIC MEETING
November 13-14-15, 1984
Hyatt Regency Dearborn

October 1984, Vol. 83, No. 46

MICHIGAN MEDICINE



About the cover

With the Presidential elections close at hand, this issue of *Michigan Medicine* is devoted to getting out the physician vote. (Photo by Kim Kauffman)

Special Report

491 November 6 Americans go to the polls to make their votes count. More and more, the way you practice medicine is determined by the government officials who will be elected from the President down. In the last few years alone, critical issues such as mandatory assignment, "Baby Doe," DRGs, licensing, hospital staff privileges and third party reimbursement for nonmedical providers have been the focus of government activity. Physicians and their eligible family members represent one million potential votes. Candidates look at where the votes come from. To help Michigan physicians cast informed votes, to make their votes count, the special report of this issue focuses on the coming elections. See you at the polls!

Features

488 Farewell from Warren Tryloff

503 The Olympic experiences of two Michigan physicians who officially served Team USA; Roy Bergman, MD

508 How the AMA's counterpart in the United Kingdom — the British Medical Association — functions, and the issues it faces; Carole Eberly

514 Compared to their colleagues in the US, British physicians live in a malpractice paradise; Carole Eberly

525 Annual Scientific Meeting registrations due now — sign up here!

528 Background information on AMA's suit over Medicare amendments

532 Ken Rowe, MD, is MSMS man in the Upper Peninsula; Elmer White

Departments

489 Letters

518 Views; Frank B. Walker, II, MD

522 MSMS/A; Nancy Crandall

536 Category I courses

541 News; Joyce Crum

542 Deaths

542 Meetings

546 Classified ads

547 Ad index

548 President's page; Louis R. Zako, MD

In next month's issue . . .

Bioethics may be all-engrossing in the coming decade, as many medical observers predict. MSMS makes the ethical problems posed by our burgeoning scientific knowledge the topic of the special report planned for the November issue of *Michigan Medicine.*

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

OCT 25 1984

A farewell from Warren Tryloff

Mr. Tryloff

After more than a quarter of a century with MSMS, I cannot leave without briefly sharing two thoughts about the relationship—past and future. This is a junction; there is a need for me to provide closure.

During my years of service, I have been privileged to work with gifted leaders and a dedicated membership. It is these individuals—you—who make MSMS today a prestigious, effective organization. I encourage your continued commitment.

Easing into retirement, I am pleased now to serve for one year as a consultant to the MSMS Board of Directors. Already the Board has given me two important duties. One is to prepare a written compilation of longstanding operating procedures. The second is to develop a marketing plan for MSMS services, including those offered through Physician Service Group, Inc. I look forward to these and other assignments.

Most of my time, however, I will spend with my wife, Nancy, at our new home in Hamilton, Ohio.

Again, my thanks and appreciation to the MSMS leadership, staff, and membership. Carry on.

Michigan State Medical Society
Bruce W. Ambrose, director

Committee on Publications
Harvey Andre, MD, Grand Rapids, chairman
Frederick W. Bryant, MD, Royal Oak
Vickers C. Hansen, MD, Manistee
Leland E. Holly II, MD, Muskegon
Richard L. Rapport, MD, Flint
Marguerite Shearer, MD, Dexter
Louis R. Zako, MD, Dearborn Heights

Editor
Judith Marr

Managing Editor
Sheri W. Greenhoe

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

MICHIGAN MEDICINE (ISSN 0026-2293) is the official journal of the Michigan State Medical Society, published under the direction of the Publications Committee. Published five times a month, 60 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $30.00; single copies, $1.50. Additional postage: Canada, $1 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to articles, news, exchanges and advertising should be addressed to Sheri W. Greenhoe and address changes to Peg Berry, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517-337-1351.

© 1984 Michigan State Medical Society

We must nourish our heritage on quality, not cost statistics

I am intrigued with your recent article, "The Delicate Issues," published in the July, 1984 **Michigan Medicine.** My fascination, however, is somewhat tempered by one area with which I take umbrage; and when I feel this strongly, I am stimulated to express my concerns.

Firstly, you have picked a winning team of physicians to discuss these issues of physicians' relationships to hospitals. I have great regard for each, not only because of his ability to relate his background about the matters at hand, but also because of the extreme honesty with which each approached the subject under discussion. The round table reminded me most strongly of a similar repartee some of us participated in many years ago under the auspices of **Medical World News.** Therefore, whatever critical remarks I have to make in this letter are ecumenical.

I cannot agree with Peter Duhamel that "some people are going to do procedures that may not have to be done, simply because they have to do work to stay alive economically ... and that this is one of the trends that you might watch for with the increasing supply of physicians in this area."

I take issue because competition will take care of the dishonest physician and peer review in the hospital medical staff continues to be the strict(est) and most opportune to prevent **dishonest** overutilization.

There will always be a few blackguards who will try to get away with almost anything; but I disagree that this is a result of the over-supply of professionals - really it is a result of culture and proper up-bringing. We must continue to deal with dishonesty as a problem for the profession itself - not as a problem for the hospital administrator.

I recognize that your panel could deal with only a limited number of delicate "issues" in the time allowed for your discussion. There is, however, a subject which you might wish to consider at your next go-around:

Why the physicians in general are rushing to "sign-up" on the dotted line with untested, divisive organizations orchestrated by government, industry, amd medical politicians - namely PPOs, PPAs and HMOs? With indignity, we seem to be scurrying like frightened rabbits to be first in line.

Why the haste?

There is no question that there is need for a broad based cost containment system in the health industry. But we are ignoring the great(est) potential (in the plans presented) for disruption of practice patterns and economics of medicine that has occurred in 50 years. There has been but puny response from the profession. We need an organized splurge of physician input - not a freeze mandated by our own national and state societies which in itself is an "admission of guilt". We pay dues to such organizations and we must insist a better, more aggressive presentation of our case before the public. It is equally important that at hospital staff levels, our leadership educate those members who rush to be first on low bidder contracts.

Let us remember that we are still the final providers (as much as I dislike that title!). We must insist that our heritage be nourished on quality and not statistical tables of cost. Unfortunately, I perceive little that is happening in this regard. There are a host of things - positive things - we can do, but not if we roll over and play dead.

This letter became longer than I expected. I am not trying to play Paul Revere. Thank you for hearing me out.

Donald N. Sweeny, Jr., MD
St. Clair Shores

Nobody votes in Conville, USA

The vote-hawks never land in Conville, USA (a "pen" name for all correctional facilities in America). Its 432,000 residents, myself included, have lost their voting rights. I am convict No. 87776 in Southern Michigan Prison (pop. 5,300), just off I-94, at Jackson.

After a company employee magazine editor expressed interest in how my "neighbors" felt about not being allowed to vote, I talked with nearly 300 of them—most of whom are chronic misfits who merely shrugged or otherwise indicated lack of concern. But there were some unusual responses to, "Did you vote when you were free?"

One came from a retired captain of a plant security team who, at age 69, is serving three to 10 years for felonious assault (he had shot a toe off his antagonist during an argument over a minor auto accident). "I have been a good American," he said. "I served on juries seven times. I have donated hundreds of hours to civic activities. When it comes to voting— well, sir, I have never shirked my duty."

I interrupted: "Duty, rather than privilege?" He flashed a big, star spangled banner smile. "Not rather than," he amended. "Duty first, then take pride in the privilege."

And this, from a 39-year-old burglar, doing 10 to 30 years as an habitual offender: "Hey, man—I ain't never voted 'cause it keeps on lookin' like no matter who gets elected president, ain't no poor folks gonna get nuthin' but more of nuthin' just like they been gettin' all 'long."

The next guy ignored my questions until I loaned him three bucks to buy a jug of spud juice - contraband, locally-distilled booze. At 42, he is serving seven

Continued on page 516

The AMA puts current information at your fingertips.

The first nationwide medical information network brings a new dimension to the way in which physicians and other health care professionals keep abreast of the latest knowledge in their profession.

Now, through the use of a low-cost computer terminal or personal computer, you can have instant access to authoritative and up-to-date information. The American Medical Association's computerized data bases place a wide range of professional resources at your fingertips, such as clinical, administrative, medical practice information, and abstracts of current clinical literature. Physicians can earn Category I, Continuing Medical Education (CME) credit using the Massachusetts General Hospital Continuing Medical Education programs or can elect to use the MGH-CME programs as informational updates or refresher courses.

Adding a new dimension to the way in which you communicate is MED/MAIL electronic mail. With the same terminal, you can send messages to your colleagues across the country or across the city . . . in minutes.

Information that could take hours to acquire through traditional channels can now be gathered in minutes, giving you valuable extra time for other important activities. And you can use the medical information network at your convenience, 24 hours a day, from your office, hospital or home.

It's surprisingly economical and professionally indispensable.

GTE Telenet

Medical Information Network

GTE

FOR SUBSCRIPTION INFORMATION PLEASE CONTACT
PHYSICIAN SERVICE GROUP, INC.
A member service subsidiary of the
MICHIGAN STATE MEDICAL SOCIETY
EAST LANSING, MICHIGAN

Ellen Vinocur Potash
Telephone 517/337-1351

Getting out the MD vote

By Judith Marr, Editor

Levin
MONDALE
FERRARO

Both Ronald Reagan and Walter Mondale are going to win the Presidential elections Nov. 6, if you ask the chairmen of the Michigan Republican and Democratic parties.

Each of them, when asked by **Michigan Medicine** early this fall, predicted a good outcome for his candidate in the coming elections. They also took the opportunity to do a little politicking themselves.

"We're optimistic here about Reagan's chances," said Spencer Abraham, chairman of the Michigan Republican Party. "The President enjoys a lot of support in Michigan. We predict an eight to 10 percent margin of votes in his favor."

Says Rick Wiener, chairman of the Democratic Party of Michigan: "Walter Mondale's chances are good, particularly in Michigan and particularly when we get the message out that Michigan has been hard hit by Reagonomics.

"Once you separate Reagan from his politics, I think the Michigan voter will say, 'Yes, he's a nice man, but his politics are disastrous for my state.'"

When approached by **Michigan Medicine** both party chairmen were deep in pre-election activities centering around appearances in Michigan of their parties' major candidates.

Abraham was making final plans for the Michigan Republican Party's convention in Detroit which would spotlight George Bush. Wiener was assessing a Labor Day rally in Detroit which featured Joan Mondale. In a few days, Geraldine Ferraro was to appear in Flint.

No shoe-in

"We're in various stages of schizophrenia around here now. We're very busy from a party perspective," commented Abraham from his suburban Lansing office. In a building the party has occupied just since December, he displayed a law degree and portraits of George Washington and Abraham Lincoln on the walls.

"Our major goals," he said, "are to get supporters of the Republican Party and the President to register to vote, and beyond that, to see that they vote."

His party has found a shocking number of unregistered voters, even among professionals, he reported. Complacency among Reagan supporters creates risk.

"Reagan isn't a shoe-in, not in Michigan at least," he said. "We always have a close Presidential election here. No one should rest.

"Members of the medical profession understand that our party is committed to private sector solutions to the nation's problems," said Abraham. "As such, we believe we have a much closer philosophy to most physicians' than the Democratic party has. Our party's approach, therefore, should be appealing to MSMS members.

"It is clear to me that the direction of the Democratic Party is far to the left. It bodes badly for the private sector of health care delivery. The prospects for the problems of the medical profession in the long range are not appealing."

The Republican Party is moving more in the direction of the private sector and offers a much more attractive option for the

Abraham

Wiener

problems of the future, he claimed. What physicians should be looking at, he advised, is the instinctive reactions of future office holders.

"The Republican instinct is to let the professionals set the agenda and deliver services with a minimal amount of interference.

Michigan vision

Getting in his own licks, the Democratic party Chairman declared, "We have a candidate running for President who, unlike Ronald Reagan, has a vision of the future which includes Michigan.

"If we in Michigan have one big concern it should be that we not be the stepsister of the country in terms of jobs and sharing in economic recovery. Our state has been the hardest hit by the recession, and the politics of the Reagan administration have made it all the more difficult for us to share in the recovery.

"If you look at the actions of the Reagan administration, you find that the slogan of 'America First' often translates into 'Michigan Last.'

"Michigan is a pivotal state in this year's Presidential election," he continued. "We have an opportunity to shape the country in the next four years by what we do in the Presidential race. The sharp difference between tickets translate to how the country is run.

"There's a lot more at stake if you look at the importance of the budget deficit on future generations, at Reagan's policies on war and peace, at the failure of the Republican platform to include women as partners under the Constitution."

His party's emphasis also will be on getting out the vote, said Wiener.

"The job of the party is to take the message of its candidates and deliver it at the grass roots level to the voters. That's what we're about this fall."

Just prior to the **Michigan Medicine** interview, newspapers had announced a major Republican effort to target the congressional seats of Democrats Howard Wolpe, Third District (Kalamazoo, Calhoun and Eaton Counties); Bob Carr, Sixth District (Ingham, Livingston counties and part of Oakland county) and Donald Albosta, Tenth District (mid-Michigan, including most of 15 counties and parts of three others). There, said the papers, the Republicans would concentrate much money and effort to defeat the incumbents.

Abraham explained that this is a national party decision, based on the historically strong Republican vote in those districts.

"At heart, the majority of voters in those areas are Republican," he said. "As a consequence, our folks think that if we can just get these voters back in our Congressional candidates' columns, our candidates could win.

"We (the Michigan Republicans) will be out working hard in all congressional elections in the state," he continued. "The national party is clearly going to put its resources in those three races. And if the Reagan majority is big enough, we may succeed. We will be pulling out the stops to do that. Our chances are not bad."

(The Republicans are wasting their time, however, said Wiener.)

"All three Democratic congressional incumbents will be reelected," he predicted. "The Republicans would do better to save their dollars and spend them on the Fifth and Eleventh District races. We think we stand an excellent chance of picking up seats there."

In every election, Congressmen Wolpe, Carr and Albosta have increased their majorities, reminded Wiener.

"This is a tribute to their hard work, and their constituent service. Each comes home often and meets with the people at the grass roots level. That's why they are able to attract the independent voters and open-minded Republicans."

Wiener talked proudly of US Senator and incumbent Democrat Carl Levin, who is opposed this year by Republican challenger Jack Lousma, former astronaut.

"Our US senator has shown by his hands-on experience and first-hand knowledge of Michigan that he knows our problems and knows how to go about solving them," he said.

Good shot

Abraham admitted he feels Lousma is vulnerable. But he is optimistic, he said. "Once Lousma's record is known, he'll have a real good shot at winning."

The Michigan Democratic Party works out of the former MSMS headquarters building at 606 Townsend Street, Lansing. An historical marker on the front lawn tells of the home's design by noted Lansing architect of the 1800s, Darius Moon, and of its succession of owners, including MSMS.

Off the chairman's office in the bay at the front of the old house is a lavender and black tiled bath. On his desk is a coffee cup with the message, "I love liberals—somebody's got to do it." Other cups on the desk display tongue-in-cheek definitions of Republicans and Democrats.

Wiener was elected party chairman 18 months ago after prior service as political director for Governor James Blanchard during his campaign for the governorship. He also had served as field director for the US senatorial campaigns of Donald W. Riegle and Carl Levin.

His Republican counterpart, Abraham, also was elected to his party's top post 18 months ago. There is talk of his being considered for a national party post.

parTICIpaTion 84

How AMPAC and MDPAC are working to get out the vote

By Thomas R. Berglund, MD

Government is heavily involved in medicine; physicians should be equally involved in politics.

Issues facing medicine on the federal level include Federal Trade Commission rules, health planning, cigarette liability and safety, Baby Doe decisions, use of heroin for cancer patients, organ transplantation, Medicaid funding; vaccine compensation and professional liability.

If tolling of these issues isn't enough to get you involved, let me add the battle cries of Medicare fee freeze and mandatory assignment under Medicare.

The AMA's defeat of the mandatory assignment proposal alone saved each physician who treats Medicare patients enough to pay for a sustaining membership in AMPAC several times!

But the fight is just beginning as our nation's lawmakers increasingly are convinced that physicians' costs must be curtailed to save the national health care programs.

Let me tell you what the American Medical Political Action Committee (AMPAC) has been doing as we approach the national elections.

AMPAC was formed as a separate organization by the American Medical Association in 1961 to help elect members of Congress who were supportive of medicine's goals. In 1980, fol-

Continued on page 494

A Portage family physician, Doctor Berglund is secretary of the AMPAC Board. He also is chairman of the MSMS Board of Directors.

By Thomas E. Stone, MD

Campaign '84 soon will be over. Positions have been taken, lines drawn; and in a few short weeks the electorate will decide.

The Michigan Doctors Political Action Committee (MDPAC) has been in this "great game" for well over a year. Our activities have followed the Participation '84 theme established at the biennial AMPAC Political Education Conference in September, 1983.

Over 40 Michigan physicians, spouses, and the MSMS staff attended this Washington, DC meeting. Purpose of the conference was to ". . . bring professionals and their families closer to the political process and to get us as professionals to continue to work together within the political structure to make our voices, individually and collectively, heard on the many issues that confront our great country." We combined this meeting with visits to each of our Michigan Congressmen and to Senator Carl Levin.

One of the election year efforts encouraged by AMPAC was attendance of a physician delegate or alternate from each of the 50 states at the two major party political conventions. Clare Johnson, MD, Pontiac emergency physician, represented Michigan physicians at the GOP Convention in Dallas (See related article, page 498). As a spinoff of this effort, we learned a great deal regarding the delegate selection process and are confident in the future we will have delegates to both national conventions.

What's happened

Although MDPAC's work continues from election to election, our official 1984 election year effort started in January. At this first meeting of the MDPAC board, we looked at the coming campaign from a broad perspective: what races might be close; who might run (and for what). We appointed members to our Candidate Selection Committee and adopted a tentative budget.

As the campaign developed, so did the intensity of our activities. We have continued to build and refine our plans, strategy, and goals.

This year we also requested AMPAC to conduct a "benchmark survey" on behalf of an incumbent congressman. This survey helped the candidate assess the effectiveness of his performance, to more scientifically allocate campaign resources and to formulate optimum election strategy.

To further understand the nature of politics and the election process, AMPAC and MDPAC presented a political action seminar in May, which emphasized the changing nature of the American political scene, the role of PACs, and how we can participate in the legislative process.

Central to MDPAC's participation is the work of the Candidate Selection Committee, chaired this year by Peter Duhamel, MD, Rochester. His committee made recommendations for candidate

Continued on page 494

Doctor Stone, a Muskegon urologist, is chairman of MDPAC.

Artinian

Vincent

MD candidates

Two MSMS members are running for public office in the Nov. 6 general elections. Both are candidates for the boards of education of state universities.

Charles G. Artinian, MD, Birmingham cardiologist, is the Republican candidate for the Board of Governors of Wayne State University.

He is a clinical assistant professor of medicine at WSU School of Medicine, a fellow of the American College of Cardiology and a diplomate of the American Board of Internal Medicine. He is a member of the National Council on Clinical Cardiology of the American Heart Association.

Charles C. Vincent, MD, Detroit obstetrician/gynecologist, is the Democratic party's nominee to replace MSU Board of Trustees member Blanche Martin of East Lansing.

Doctor Vincent is an associate dean of admissions at Wayne State University School of Medicine, and vice chairman of the Michigan Board of Medicine.

AMPAC/Continued

lowing Federal Election Law amendments, AMPAC was officially taken back into the AMA organization. AMPAC now is headquartered in the AMA Department of Political Education and its funds are segregated from the AMA's.

AMPAC operates on a two year cycle. Our dues money is largely spent during the last six months of each cycle. In 1983-84, AMPAC will have spent about $3.6 million on political campaigns.

AMPAC is spending $350,000 of this total on behalf of candidates without their knowledge. These independent AMPAC expenditures always are positive and include direct mail, TV and radio spots and in-kind support. We also are experimenting with cable TV and ethnic radio spots.

Another area of innovation is benchmark surveys done early in campaigns. This year AMPAC is doing 30 such surveys of voter preferences on candidates and issues for 15 Republicans and 15 Democrats, at a cost of $300,000.

AMPAC's major emphasis is on direct candidate support. AMPAC's Congressional Review Committee meets in March of each election year for a weekend retreat, when committee members go over all 435 House races and the 33 Senate races that are up for election that fall. A preliminary budget is established.

By law AMPAC can contribute $5,000 per primary and $5,000 per general election race to a candidate. Simple arithmetic will tell you that $10,000 per race will use $4,680,000. On occasion, AMPAC may use additional funds in both the Democratic and Republican primary elections.

November 6 is just around the corner. All of us should exercise our constitutional right and get out and vote. AMPAC can help finance a campaign, but our work will go for naught if our candidate does not receive enough votes.

Immediately after the 1984 elections your AMPAC Board will begin the job of gearing up for the 1986 election cycle. Your 1985 MDPAC/AMPAC dues as well as your MSMS AMA dues will be payable in December.

Won't you send in $150 for a sustaining membership so AMPAC can continue to elect friends? Won't you also continue your AMA dues so your AMA Washington lobbyists can continue to keep medicine free?

MDPAC/Continued

support to the MDPAC board in April. The Board acted favorably on these recommendations and made contributions to 15 Michigan House candidates. In addition, both candidates for the Republican nomination for the US Senate seat, now held by Senator Carl Levin, attended this April meeting. Former Congressman James Dunn and astronaut Jack Lousma made presentations to the Board. Senator Carl Levin spoke to the MDPAC Board of Directors in September.

Early in July, we reviewed all 110 Michigan House seats, as well as seats for the US Congress. We made recommendations for support and requests for contributions on behalf of a number of congressional candidates and submitted them to the AMPAC board for consideration. We gave selective support to House candidates prior to the August primary. We held our final selection meeting on September 5, where we reviewed recommendations for the general election. It is important to note that whenever possible, and MDPAC board member delivers our contributions personally to the candidates.

90 percent

If our previous record is any measure, we can expect close to a 90 percent MDPAC success rate in selecting winners. This is the result of careful planning and study of polling data, demographics and voting patterns, and most importantly, of contact with the physicians living in the candidates' districts. This "backhome contact" is vital to our success.

As this year's campaign ends, MSMS members can be assured that your PAC has been active. We are pleased to have played a role in this election.

We would further remind MSMS members that political action and involvement no longer are options, but rather necessities, if we are to survive as a profession.

Here are health care views of candidates Levin and Lousma

Michigan Medicine **recently wrote Sen. Carl Levin and his challenger, Jack Lousma, for one of the two US Senate seats from Michigan. To help our physician readers better weigh the views of these major candidates in the coming election, we asked them both to discuss briefly their stands and outlooks for national policy on health care delivery. The following two articles are their replies.**

Levin:

Growth in health care spending has generally outpaced growth in the economy. Expenditures by the Medicare program under the Hospital Insurance Trust Fund increased approximately 19 percent per year in recent years. This growth has serious implications for Medicare beneficiaries and for the trust fund, which projections indicate could be exhausted by the early 1990s.

Congress and the executive branch have focused on a number of ways to bring federal spending for health care under some degree of control. A major effort in this direction was the enactment in 1983 of the Prospective Payment System (PPS), which was intended to provide stable funding for hospitals and to provide incentives for hospitals to contain their costs, thus reducing costs to the Medicare program.

Some flaws

In the context of the PPS, numerous questions have been raised concerning the effect of the new Medicare Diagnosis Related Group-based payment system on the components of the health care industry. For example, some providers have said there will be pressure on hospitals to reduce care for patients. That question must be monitored closely; but the system should be allowed to work for a while before conclusions are reached.

Some apparent flaws in the system already have been found.

In November of last year, I met with Health Care Financing Administration Administrator Carolyne Davis, PhD; HHS, OMB and Census officials about concerns stemming from reimbursement designation under the Prospective Payment System that had been brought to my attention by a half dozen Michigan Hospital administrators. They included administrators from Northern Michigan Hospitals, Marquette General, Munson Medical Center and Owosso's Memorial Hospital. Fortunately, because we acted quickly, some of the problems were averted.

Other concerns about the PPS also are on the way to being resolved. For example, hospitals that serve a disproportionately large number of Medicare or low-income individuals may be treating patients who are more severely ill than the average patient. Congress was concerned about this disparity and directed the Secretary of HHS to "provide exceptions and adjustments to the prospective payment made to such providers."

Although the provision was enacted by Congress as part of the Social Security Amendments of 1983, the Department did not act to implement it. In May of 1984, I wrote to Secretary Heckler to urge her to put the provision to work. Recent Congressional action requires the Secretary to identify such providers by December 31. I think it's important that the mandate of the Congress be carried out by the Department and I intend to continue to work with HHS to see that it is.

I also cosponsored a measure contained in the Act which directs the HHS secretary to report to Congress on the *regional disparity* in payment amounts to specific hospitals.

Regulatory process

With respect to the regulatory process in general, I have been a strong advocate of legislative initiatives designed to increase

Lousma

Levin

Congressional review of the regulatory process as it applies to the professions, and to all other segments of our society.

For example, an amendment I introduced to the Federal Trade Commission's reauthorization bill provided Congress with the authority to review FTC regulations before they took effect and to veto them if they were unreasonable or unnecessary. The Senate approved legislation I sponsored which would have established this legislative review mechanism on a government-wide basis.

Recently, however, the Supreme Court ruled that some forms of the legislative veto are unconstitutional. As a result, I have worked with Senators Boren (D-Oklahoma) and Grassley (R-Iowa) to develop a different approach which will satisfy the Court's objections.

I intend to continue to push for legislative review and other mechanisms which bring some needed accountability to the regulatory process, and to ensure that unelected bureaucrats are not given extensive authority over our lives.

I supported the compromise provision included in the FTC's reauthorization bill restricting the Commission's jurisdiction over state-licensed professionals. The provision would prohibit the FTC from interfering with legitimate state regulation of professionals over such matters as training and educational requirements for licensure or quality of services. The FTC would be permitted only to continue to exercise its authority to protect consumers from certain anticompetitive business and commercial practices.

The challenges which lie ahead in the field of health care will continue to be complex. A continued dialogue between government, health providers and consumers will be essential for there to be an equitable resolution of controversial issues.

I will do my part to encourage and participate in that dialogue.

Lousma:

Our nation is currently facing a crisis in its health care delivery system. In the months and years ahead, critical decisions must be made to insure the delivery of quality health care to all Americans.

From 1970 to 1983, medical costs rose 192 percent, compared to a 157 percent rise in the consumer price index. This huge increase in costs means that we now face the prospect of a two-tiered health care delivery system: One for those with the ability to pay; another, at much lower levels of quality, for low income persons. This is a situation which we must not allow to occur.

Competition Quality

To avoid it, I will support efforts to make our health care system more competitive, without endangering the quality of care. The institution of diagnosis related groups (DRGs) was a step in the right direction of cost containment. The previous system provided few incentives for hospitals to become more efficient, and Medicine paid widely different amounts for similar treatments to hospitals around the country, with no apparent differences in quality. DRGs provide some incentives for cost control and should lead to more uniformity in prices.

While DRGs are a positive step, other reforms must be made to control costs. One measure which has great promise is the proposal to change the cost-sharing structure for Medicare hospitalization insurance.

By establishing coverage for catastrophic illness, while decreasing protection for short-term hospital stays, this reform would lead individuals to rethink the way they currently purchase medical services.

Another reform, if it can be shown to decrease that government's financial burden, is the institution of medical IRAs. Under this plan, funds from an IRA could be withdrawn at age 59 for the purchase of medical insurance or medical care. As consumers would be spending their own savings on medical care, they would have an incentive to find the best care at the lowest prices.

In addition, we need to insure prompt payment of the cost-cutting incentives to hospitals provided under the Tax Equity and Fiscal Responsibility Act of 1982. Currently, such payments can be delayed until cost reports are settled, which can take years. In order to insure that these incentives are effective, we need to streamline this payment process, while insuring that abuses of the system do not occur.

Besides cost containment, there are other issues of concern to physicians in this election year. One of these issues is taxes. Carl Levin voted for higher taxes 62 times during his six year term in the Senate. Most significantly, he voted against President Reagan's Economic Recovery Tax Act of 1981. Besides reducing personal income taxes 25 percent across the board over three years, the Act: 1) reduced the top tax rate on investment, or "unearned" income from 70 to 50 percent; 2) reduced the maximum rate on capital gains taxes from 28 to 20 percent; 3) increased from $175,625 to $600,000 by 1987 the total amount of estate and gift tax transfers that could be exempt from estate and gift taxes; 4) increased the annual gift tax exclusion from $3,000 to $10,000 per donee with an unlimited exclusion for tuition and medical expenses.

I would have voted for this act, which has been the cornerstone of our economic recovery. In addition, I pledge not to vote for a tax increase during my six year Senate term. This is the type of logic which my opponent does not understand, but which the voters and I understand clearly: higher taxes stifle economic growth and productivity. They would crush our nation's economic recovery, and I will oppose them at every turn.

more on page 498

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android®/5 Buccal mg./10 Oral mg./25 Oral mg.

Methyltestosterone U.S.P. Tablets

ANDROID®/F

Fluoxymesterone U.S.P. Tablets, 10 mg.

SPECIAL REPORT/Continued

By Willah Weddon

Clare Johnson, MD, served as GOP Convention delegate

In Dallas at an AMA reception honoring Health and Human Services Secretary Margaret Heckler was Clare Johnson, MD, Pontiac, right, one of 20 MD delegates to the Republican National Convention. With him at the reception, from left, are Thomas R. Berglund, MD, Portage, chairman of the MSMS Board of Directors and secretary, American Medical Political Action Committee; and John J. Coury Jr., MD, Port Huron, chairman, AMA Board of Trustees.

Attending a national political convention was "a very interesting experience," assesses Clare G. Johnson, MD, of Pontiac.

Doctor Johnson was one of 20 physician delegates who took part in the Republican National Convention in Dallas the latter part of August.

Exciting

"There was a wide variety of people there," Doctor Johnson recalls. "It was exciting to see the President and Vice-President of the United States so close by, and it was a harmonious convention."

But that didn't mean there was little to do. "We (delegates) arrived for 10 am sessions Monday and Tuesday, and 8 pm sessions of two to three hours each, for four evenings."

The intricacies of transportation and security during a national convention also intrigued the Pontiac physician, who is currently the medical director of the Emergency Department at Saginaw General Hospital.

With him at the convention were his wife, Patsy Lou, and their 18-year-old son, Greg. Greg served as a member of the "Scatterblitzers," a group sent to the convention by the State Republican Party. They campaigned along the way from Michigan, stopping at Springfield, Illinois; St. Louis, and Oklahoma City. While in Dallas, the students helped with transportation for the convention.

Doctor Johnson recommends other physicians go to national conventions as delegates and feels strongly about their participation in politics.

"I think it's very important we get more physicians involved in the political process, whether it's at the grass roots, county, state or national level," he says.

Why does such a busy man take time for politics? The answer may lie in his remark, "We need to be active in the governmental process because it concerns not only our current society but that of our children and grandchildren."

Ms. Weddon is a Lansing area freelance writer.

LOUSMA/Continued

Strengthen economy

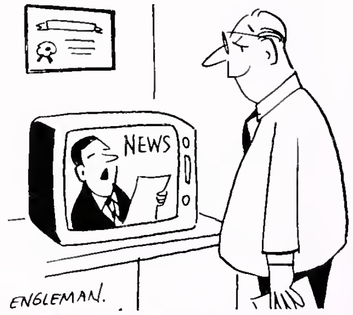
There are other steps which I will take to strengthen Michigan's economy. I will fight to reverse the drain of money from Michigan to Washington. Currently, Michigan gets back only 79 cents for every dollar it pays in taxes. I will reverse this trend by bringing more government contracts to our state.

My experience in the military, in NASA, and as an engineer, gives me the expertise necessary to bring defense and high technology jobs to Michigan. I will support job training programs for youth, enterprise zones, reduced federal regulation and increased farm exports. These goals, while not directly applicable to the medical profession, will strengthen Michigan's economy to the advantage of everyone, including medical professionals.

As we face the problems of the health care industry, we must insure that all voices are heard. Too often in the past, commissions have been established to study the problems with medical care that have not adequately represented the interests of health care providers.

My goals as a US Senator will be to reform the health care system through a process in which all voices are heard. Any reforms need to be equitable both to the providers and recipients of medical care.

We cannot allow health care services to be rationed. Quality health care for all people is something which we must fight to preserve. I pledge to be a leader in that fight.



"It's been a quiet day . . . both presidential candidates are suffering from laryngitis . . .!"

THE SPECIALIST

YOUR TOTAL MEDICAL OFFICE MANAGEMENT RESOURCE

The **Specialist** was designed in conjunction with physicians to fit the physician's practice needs. Menu-screen driven, the **Specialist** improves office efficiency in patient/insurance billing, practice management reporting, appointment scheduling, maintaining general office information, and overall practice correspondence.

The **Specialist** can support multiple users with up to 16 IBM Personal Computer workstations, accommodating in excess of 50,000 patients.

Patient/Insurance Billing

The **Specialist** was designed to ease the patient billing and claims processing tasks.

It allows for automatic input into the Blue Shield system, split insurance payments between overlapping insurance companies, and an extremely easy one time set-up for any insurance form used in the practice. Super bills, containing much of the detail information required for patients' private insurance forms, are generated to aid patient claim submission.

The **Specialist** keeps accurate patient records on billings, balances (current and past due), and payments. Cycle billing, finance charge assessments, and dunning letters are also features of patient billing.

The patient/insurance billing portions of the **Specialist** integrate with virtually any business accounting general ledger package.

General Office Duties

By scheduling appointments, printing recall labels, chart-pull lists and charge slips, and accommodating the offices word processing requirements, the **Specialist** reduces the administrative time needed for these routine tasks, while improving the accuracy of the information involved.

Practice Management Reporting

Practice productivity reports are generated in the **Specialist** for such things as aged accounts receivable, analysis of services performed, inactive patient lists, referral summaries and other types of control reports that were previously beyond the scope of the office routine.

The **Specialist** is also capable of accommodating custom reports that are unique to each practice, providing the physician with additional system flexibility.

Because of the multiple levels of security in the **Specialist**, sensitive information remains confidential and secure.

See the **Specialist** demonstrated at the MSMS Annual Scientific Meeting, November 13-15, Dearborn Hyatt Regency, MMCA Hospitality Suite.

Investment Protection Plan

The **Specialist** is offered as your total medical office management resource, including hardware, software, installation management, user training, on-going support, service and consulting, as well as free system updates for the first year.

We are so confident the **Specialist** will fulfill your practice's needs that we are offering a 60-day money back guarantee.

MAKE THE SPECIALIST YOUR TOTAL OFFICE MANAGEMENT RESOURCE!

MMCA MINI MICRO COMPUTER APPLICATIONS, INC.

I am interested in more information on the **Specialist.** Please provide additional details.

Name ____________________
Address ____________________
City ____________________
State __________ Zip ________
Phone ( ) ________________
No. of Physicians in practice ___
Physician Specialty ____________

MMCA MINI MICRO COMPUTER APPLICATIONS, INC.

1383 Woodward Avenue, Suite 204
Bloomfield Hills, MI 48013
(313) 335-1400

Just once each day...

First-step blood pressure control with optimal simplicity

Benefits diuretics cannot offer... Once-daily INDERAL LA (propranolol hydrochloride) with its smooth 24-hour control of blood pressure provides a high degree of patient acceptance without potassium problems, plus the cardiovascular benefits of the world's leading beta blocker.

Experience no other beta blocker can match... Once-daily INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.

80
100
120
140
160
180
200
220
240
SPHYGMOMANOMETER

Start with 80 mg once daily... Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES

Just once each day for initial therapy in hypertension.

80 mg
120 mg
160 mg

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

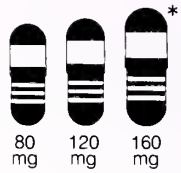
Ayerst

Just once each day for initial therapy in HYPERTENSION.

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

> IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General.* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia, visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

8950/284

Ayerst. AYERST LABORATORIES
New York, N.Y. 10017

Just once each day...

Michigan has two Olympics physicians

"Michigan can be very proud to have two of the six physicians who were selected from the entire United States to take care of our Olympic athletes during the recent summer games."

So wrote Mrs. Eleanor J. Finger, office manager for Ben R. Mayne, MD, Saginaw orthopedic surgeon who was one of the two Michigan physicians in Los Angeles in late July and early August for the games. She wrote **Michigan Medicine** of his achievement.

Doctor Mayne's story follows on these pages, along with a fascinating first-hand account by Michigan's other official Olympic physician, Roy T. Bergman, MD, Marquette orthopedic surgeon.

The other four on the medical team were orthopedic surgeon William McDaniel, MD, of the US Navy; obstetrician/gynecologist Emily Lutz, MD, Circleville, Ohio; chiropractor Eileen Hayworth and team leader Robert Leach, MD, Boston orthopod. They served under chief team physician, Tenafly, NJ, general surgeon Irving Dardik, MD.

Doctor Ben Mayne takes the pulse of an Olympic contestant.

Ben R. Mayne, MD, put his interest in sports medicine to good use when he served as team physician for three Olympic events: field hockey, gymnastics and equestrian jumping.

Doctor Mayne began working his way through the Olympic ranks by starting out at the US Olympic Training Center in Colorado Springs four years ago. He has served as physician for the US Women's Field Hockey Team during those four years. This active participation has taken him to Holland, Australia and Malaysia.

Doctor Mayne has been active on the sports scene locally, serving as team physician for Arthur Hill High School for several years. There he has followed in the footsteps of his father, Harold E. Mayne, MD, who also served long years as Arthur Hill's team physician.

Before the Summer Olympics, Doctor Mayne observed "I'm looking forward to the games with great anticipation. Despite some controversy over how some foreign governments subsidize their athletes, we still depend upon free enterprise for support. Much of the professional assistance, including mine, is a donation; large corporation gifts, as well as those by individuals, make it possible to finance our teams."

Doctor Mayne told the "Hospital Tribune" newspaper that by serving as a team physician he was "getting a lot back in experience and humanism. I'm paying my country back for the great living it has offered me."

He credited the athletes for their hard work and perserverence, particularly those who postponed careers and life choices to continue training through the 1980 Olympic games boycott to compete in the '84 games.

After their effort, he said, "is it hard to understand that I travel at my own expense and figure I've given up eight to 10 weeks a year...?"

Doctory Mayne, age 48, trained three times a week with a Nautilus machine prior to the games, and ran to keep in shape—even though he hates running. "You can't show up with a pot belly and get credibility," he told the "Tribune."

Doctor Mayne resides in Saginaw Township with his wife, Lynn. Son Ben R., III, is presently in his second year of medical school, and daughter, Amy, is in her third year of nurse's training, both at the University of Michigan.

By Roy T. Bergman, MD

Sustaining athletes' world class ultimate payoff for Olympic MD

Doctor Bergman provides therapy for US Olympic swimming champion Rowdy Gaines.

For me, the road to the 1984 Summer Olympic Games Medical Staff appointment began in 1978. That was the year I was invited to serve as one of 20 to 30 physicians for the first-ever National Sports Festival at Colorado Springs, Colorado. This event, sponsored by the United States Olympic Committee, (USOC) occurs in every year except the year of the Olympics.

That experience, plus my lifelong interest in athletics, led to my continued involvement in Olympic Sportsmedicine, which has now culminated in the '84 Games appointment.

Doctor Bergman, of Escanaba, is an orthopedic surgeon just returned from serving as one of six team physicians for the 1984 US Olympic athletes.

First taste

Although I was unaware of it at the time, my performance at that initial Sports Festival was being evaluated. Shortly after I returned home I received a letter advising me that I had been selected as one of five physicians to accompany our 1979 Pan American Team to the Games in San Juan, Puerto Rico. That was my first taste of international travel with a team of world class athletes, and I enjoyed it immensely.

Following the 1979 Pan American Games, I was deeply involved in Olympic and National Team Sportsmedicine activities, some of which follow:

1979 - National Sports Festival
1979 - Pan American Games
1980 - Winter Olympic Games
1980 - Summer Olympic Games Medical Staff (boycotted)
1980 - US Rowing Teams European Tour
1981 - Head Physician at the National Sports Festival in Syracuse, New York
1982 - World Championships of Basketball in Cali, Columbia
1983 - Head Physician at the Pan American Games in Caracas, Venezuela
1984 - Staff Physician at the Summer Olympic Games in Los Angeles, California

Along the way I covered various athletic trials, served as a member of the Medical Committee of the United States Olympic Council on Sportsmedicine, a member of the Elite Athlete Project (USOC) and the United States Olympic Committee Task Force on Drug Control. I even spent a few days testifying at various court hearings dealing with US athletes detected as violators of the International Olympic Committee drug control program.

These activities, although interesting and challenging, are time consuming. Over the past calender year, they have caused me to be absent from my solo general surgical practice for approximately three months.

This, of course, makes a considerable financial sacrifice necessary, and requires long absences from my family, as an Olympic team physician is not encouraged to bring his family along with him.

For these, as well as other reasons, I have decided to limit my future activities on this level

Continued on page 506

THE ELECTRONIC NURSE™

A computer program that can turn an Apple or IBM PC into a workhorse

THE ELECTRONIC NURSE™

What Does She Do?

- Organizes your patients' records so there is no wild scrambling for charts when the phone rings.
- Remembers 300 medications and prints a Rx faster than you can say the words.
- Makes flow charts for anything you want to follow - blood counts, drug levels, weights, milestones -
- Provides the patient with a take-home sheet including:
  - ✓ medication list with special instructions and warnings.
  - ✓ time, date and where to report for tests and studies.
  - ✓ call back and return times and dates
- Orders your lab tests and files the results when they arrive. Lets you know if a patient has not completed any tests.
- Makes a copy for the chart and also stores all data in memory for later retrieval.

Will the Staff Like Her?

They'll love her. The Electronic Nurse™ will even chart their nursing notes.

What Else Can She Do?

- Take a detailed history and give you a complete printed summary:
  - ✓ a general history, review of symptoms, etc. ready for you before you walk into the examining room.
  - ✓ specialized histories for special applications.
- Save you a LOT OF TIME. This will mean a great deal to you in this rapidly changing medical economy.

What Do I Do Now?

Call us collect, or send in the coupon on this page. We'll send you our latest catalog with complete program information.

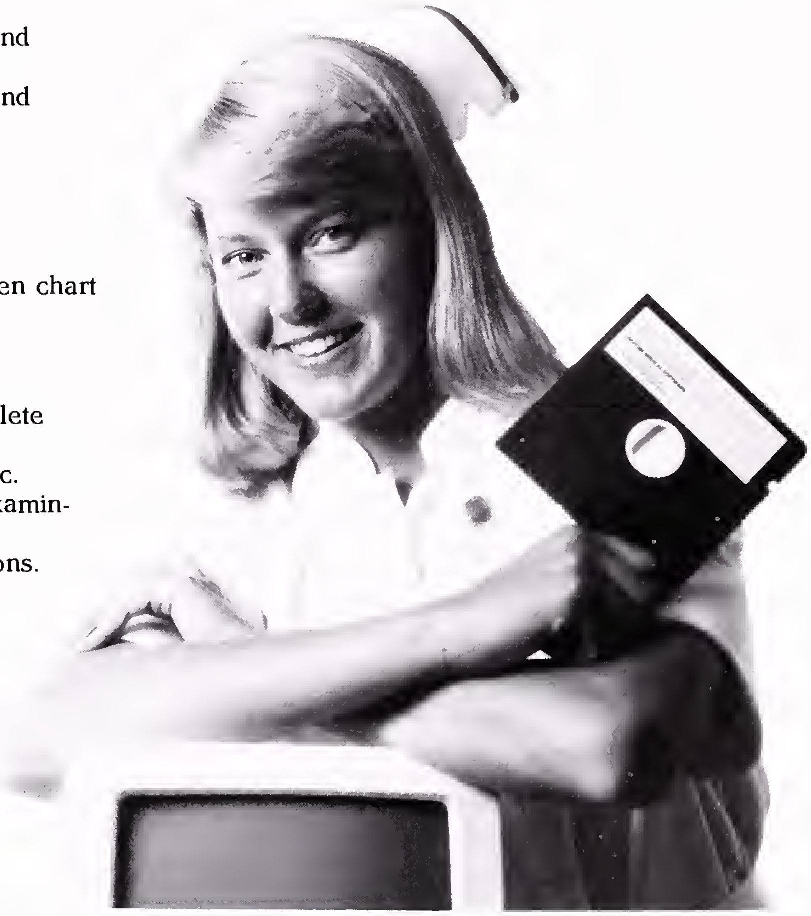
Call Dr. Messina's office at **616-725-8322.**

Our prices start at $495.00 for the basic program.

Cogitum™
MEDICAL SOFTWARE

COGITUM MEDICAL SOFTWARE
SUITE 310
1675 LEAHY STREET
MUSKEGON, MICHIGAN 49442

*APPLE - Trademark of Apple Computer, Inc.
IBM - Trademark of IBM, Inc.



Please send me your catalog and price list.

NAME ____________________

ADDRESS ____________________
____
____

PHONE ____________ SPECIALTY ____________

TYPE OF COMPUTER ____________________

SPECIAL INTERESTS ____________________

B

to an advisory or policy-making capacity, and to step aside and let other qualified physicians provide "games" coverage, which is coveted by many.

Ultimate payoff

As I have indicated, the progressive steps one goes through on the way to an Olympic Games assignment include service at the Olympic Training Center, National Sports Festival, World University Games and Pan American Games. At every step of the way you are being evaluated for competence, compatibility, ability to relate to the athletes at this level, flexibility, and the intangible element of chemistry that is necessary to function in a strange environment with other members of the medical and training staff.

The rewards of this activity are varied, but the ultimate payoff is the knowledge that you have helped your athletes/patients achieve or sustain a level of health that allows them to compete at the world class level.

Let me just make a few points here regarding a games assignment:

As one of five to six physicians responsible for the health care of approximately 600 athletes and a like number of administrative and support personnel, it is a working assignment. The good team physician is not a tourist. You must live and eat with the athletes (families are not allowed in the village), accompany them to practice and competition, cover clinic hours (sort of "sick call"), take night call on a rotating basis and be ready to intervene whenever necessary. At the intensity level of Olympic competition, one must be on one's toes at all times. You just never know when a crisis or catastrophe will occur.

Your assignments change daily, and sometimes hour to hour; consequently, flexibility is a must.

Another qualification of a good team physician is the ability to suppress your own ego and avoid getting in a competitive situation with your patients as far as media interaction is concerned. The best team doctor generally melts into the background and quietly serves.

You must realize that the only competition you're likely to see is that which you are covering. If one wants to see various Olympic events, don't be a team doctor. You just might spend your days (and nights) in a make-shift clinic or locker room.

Typical games

Let me give you an idea of a typical games experience. I'll use my own situation at Los Angeles as an example.

I arrived in Los Angeles on July 13 and spent my first night in the Airport Marriott Hotel. We would be moving into the University of Southern California Olympic Village on the fourteenth (in a domitory where I shared quarters with five athletic trainers) and returning to the Marriott daily for the processing of athletes. On our first day (the 14th) we were credentialed (identification cards, etc.), outfitted in a wardrobe by Levi Strauss Co., had pictures taken for the yearbook, and then we gave physical exams and drug control data to all incoming athletes.

This processing concluded on the 19th. Then our days were spent covering clinic and team practices until competition began on July 28.

We marched in during opening ceremonies and enjoyed that activity; but soon the reality and intensity of our role set in.

My primary coverage responsibility was boxing. Over the course of the games I was present at 345 bouts. There were two sessions of boxing daily (11 AM and 6 PM), the only exception being on August 10 the day before the finals.

As the United States had an outstanding boxing team (12 athletes who won nine gold medals, a silver and bronze), I was I busy with them every day. The only other sports I saw were one baseball game, one game of men's team handball, and some swimming and diving.

A typical day for me went something like this:

Up at 6 AM
Breakfast at 6:30
Clinic coverage 7-9:30
Leave for boxing 9:30
Cover boxing 11 AM - 2 PM
Return to the village by 2:30
Eat Lunch
Cover clinic 3-4:30
Leave for boxing 4:30
Cover boxing 6-9 PM
Return to village 9:30
Dinner 9:30
To clinic until 10:30
Bed at 11 PM

There were many positive experiences and several instances where I feel I contributed directly to the success of my athlete/patient. One of our boxers sustained a ruptured eardrum in his first bout. I patched it with a piece of cigaret paper and this modified tympanoplasty allowed him to progress to the finals, where he won a silver medal.

Another of the team tore a portion of the extensor hood on his fourth MC-P joint and thus required a pre-competition injection of marcaine (legal under IOC rules) to allow him pain-free competition. He won a gold medal, and will be operated upon to repair this defect in the near future.

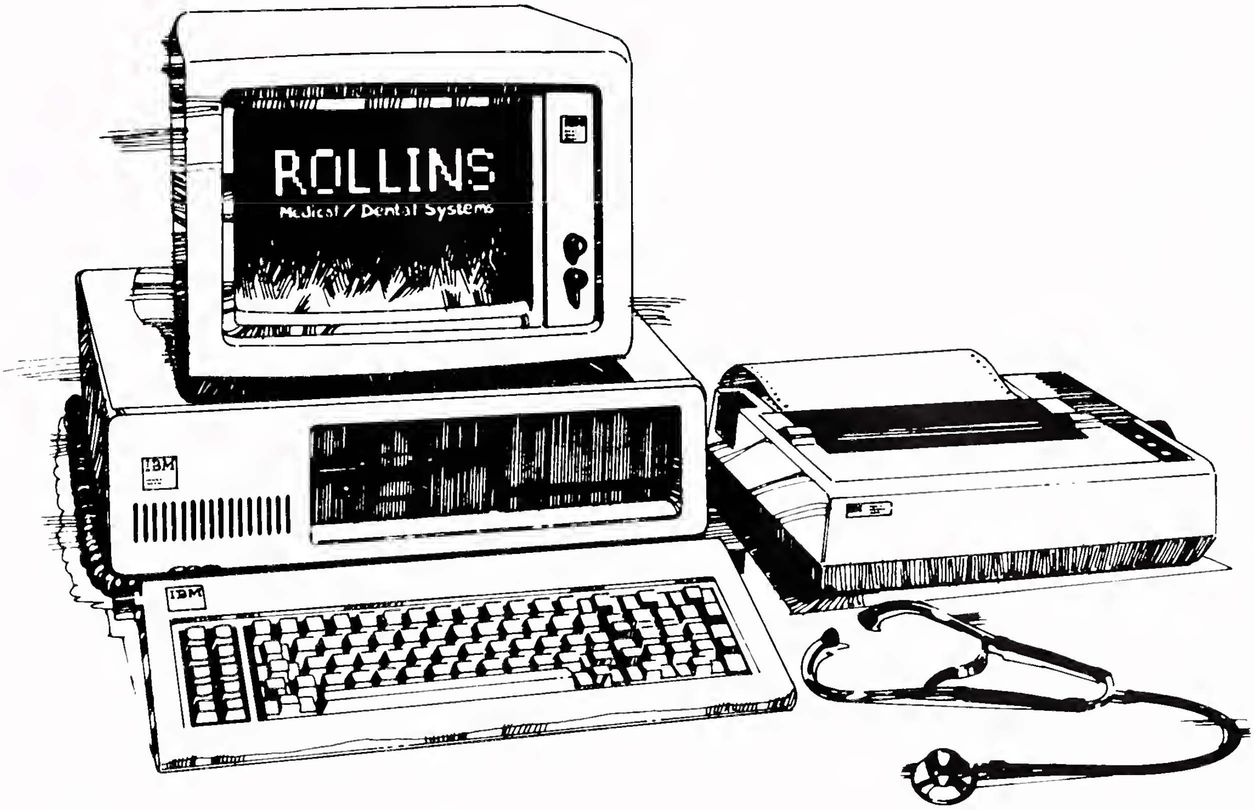
Several other team members required daily physical therapy, and some required treatment of medical illnesses ranging from VD to bronchitis, all of which I was responsible for. I am pleased to say that all responded positively and this is a source of great satisfaction for me.

Going on

All of a sudden it was over, and I was packing to return home on August 11. I passed up the closing ceremonies in favor of returning home somewhat earlier.

As I think back on my latest experience, I'm pleased that I had this once-in-a-lifetime opportunity to serve. I feel that I did my best and contributed in a very substantial way. However, I don't plan to do it again. Now it's time to go on to other things and let others get the "glory".

Tools of your trade-



Make sure they're the best.

Like any other tool you use in your practice, your computer system should be of the highest quality, so it performs consistently and reliably.

It should be specialized, designed exclusively for medical offices. It should be expandable, so it can grow with your practice. It should be backed up by the best service. And it should be continually updated to reflect changes in regulations. In short, it should be a Rollins Medical Office System.

The Rollins Medical Office System uses Rollins Medical Dental Systems quality software designed specifically for medical practices, and IBM hardware. It handles Accounts Receivable - insurance and private billing, itemized account balances, statements, and so on, so you know who owes you what and for how long

It can also do more. The Rollins Disbursement System keeps track of Accounts Payable and Payroll - even does W2, 501 and 941 forms for you. You know exactly whom you owe, how much, and for how long. You select the bills you want to pay and the computer prints the checks for you And of course all the IBM programs, from word processing to stocks management, can also be used, so you have a huge range of choices

Whether you practice alone or with a group, Rollins Medical Dental Systems has a system that can help you manage your practice more efficiently Why not choose the tool best suited to the job? Give us a call now We'll be happy to show you how it can help your practice.

ROLLINS
Medical / Dental Systems
360 Clausen Building
23100 Providence Drive
Southfield, Michigan 48075-3677
Phone (313) 423-7200

An IBM value-added remarketer

YES I'd like to know more about the Rollins Medical Office System

Name ____________________

Practice Name ____________________

Address ____________________

City ____________ State ____________

Zip ____________ Phone ____________

Mail to: ROLLINS Medical/Dental Systems
360 Clausen Bldg., 23100 Providence Dr
Southfield, MI 48075-3677

By Carole Eberly

ISLINGTON HEALTH DISTRICT
FINSBURY HEALTH CENTRE
Tel. 837 0031
GENERAL MEDICAL PRACTITIONER SERVICES
Dr. F. C. Gormley & Dr. P. Jurek Tel. 837 9750
Dr. L. Lemonsky & Partners Tel. 837 9837
GENERAL DENTAL SERVICES
Mr. M. Kleinlerer
COMMUNITY HEALTH SERVICES
Child Health
Dental
Parents & Toddlers Group
Vision
Children's Services
Alcohol Counselling
Bathing Centre
Adult Services
Nursing Services
FOR FURTHER DETAILS PLEASE ENQUIRE WITHIN

A patient emerges from the Finsbury Health Centre of the Islington Health District. The sign on the fence says this is the office of Dr. Paul Jurek, and is typical, says our author, of British primary health care facilities.

British Medical Association at center of medical politics

London, England—As British doctors are in the business of treating people instead of "messing around with unions," about 70 percent of the nation's physicians are members of the British Medical Association (BMA).

"We provide members with a whole range of benefits, not the least of which is dealing with unions," said Tony Thistlewaite, spokesman for the BMA.

And in a country where unionism is a way of life, sophistication and patience are necessary in an area where physicians may have little expertise.

Unions everywhere

"It used to be that GPs were kind of folksy people in small towns," Thistlewaite said. "Now, however, with the unions everywhere, a GP has to mind his Ps and Qs."

GPs are the backbone of British medicine, with 30,000 of them to treat the 56 million inhabitants. All medical treatment, under the English system of free treatment for everyone, originates with the GPs. Everyone is required to see his local GP before being referred on for any specialized treatment.

Seven years ago the BMA polled its membership to see what physicians wanted from the organization. The answer was more services and help in dealing with unions.

"As a result we now have 200 regional offices set up which offer advice on industrial relations problems and other issues that might arise," Thistlewaite said. "After all, doctors are in the business of treating people, not messing around with unions."

In the days before the militant unions moved into British hospitals and clinics, Thistlewaite said if a nurse tripped over a telephone cord, the matter was between herself and the doctor. Now, however, he said, all sorts

---

Ms. Eberly is a Lansing-area freelance writer. Stationed in London for a month this summer as part of a master's degree program in journalism, she covered aspects of the British medical care scene for *Michigan Medicine* readers. Her articles follow on these pages. More will appear in coming issues.

of paperwork and headaches can occur.

Unions in Britain protect all health care workers, from nurses and technicians to maintenance personnel. And the unions are much more militant than in the US. Lurking in the minds of British doctors is always the possibility of a strike by health care workers.

Ironically, the BMA itself is a union, although Thistlewaite is quick to point out it's a professional, not closed shop, industrial, union.

Also, BMA members do not strike.

"Members join voluntarily," he said. "It's not a requirement for employment."

As a union, the BMA negotiates the salaries of doctors with government officals. It has a negotiating board made up of representatives from the four major medical groups of the BMA - GPs, junior hospital doctors, senior hospital doctors and community medicine doctors.

After negotiations, an independent review body gives its recommendations to the government which acts on the salary levels.

Originally the review panel met every three years, but with inflation running high in recent times, it passes on recommendations annually.

Currently GPs make about £20,000 - about $26,000. The highest paid surgeons make about £40,000 - about $52,000.

Although the salaries are much lower than in the US, Thistlewaite said the National Health Service "has been a fantastic boon."

The NHS is the branch of government responsible for running health care in Britain.

"The doctors like it, although not the lower pay," said Thistlewaite. "They don't have the money problems of collecting from patients or paying workers."

All checks come directly from the government to all health care workers. He said in many ways the convenience of the system makes up for the lower salaries. He cited examples of doctors who left Britain for the US because of the higher pay, only to return shortly because of the convenience of having the government take over the bookkeeping functions.

Focus changes

It costs about $150 annually to join the BMA. It has more than 73,000 members overseas and in Britain. About 66,000 retired and active doctors belong from the United Kingdom.

In addition to help in dealing with the unions, members receive the highly-respected **British Medical Journal** weekly. Also, there is legal advice, taxation services and relocation aid for members. They also receive special rates for clinical and scientific meetings of the BMA.

For instance, a symposium on "Doctors and the Courts" is scheduled this month. On the agenda are such workshops as confidentiality and the medical report, medical evidence and the coroner's court, and medical evidence in preparing a court case. The fee for non-members is about $75, while BMA members will pay about $27. The fee includes lunch and, of course, afternoon tea.

Although the focus of the BMA has changed in recent years to deal with union problems, its basic aim has remained the same since its establishment in 1832.

"The two basic aims are to uphold the honor and interest of the medical profession and to promote the science of medicine." said Thistlewaite.

The BMA also frequently carries out investigations on issues which influence national legislation. Issues such as drinking and driving, hypothermia in the elderly and the provision of medical services for oil rigs have been a few looked into.

While the BMA is headquartered in London, the organization makes a concerted effort to be a national organization.

"Every year we hold our annual meeting in a different part of Britain," said Thistlewaite. This year the meeting, held the first part of July, was in Manchester.

The 600-member Representative Body is the policy-making group within the organization. The body considers reports of the past year's work and decides how the BMA is to deal with forthcoming issues.

"The BMA continues to be at the center of medical politics," explains one booklet from the BMA. "Doctors, as never before, are concerned about the effects of changes in society on their patients and themselves. The BMA provides the one credible organizaton for taking on these issues and formulating new initiatives and policies."

Leading issues

One of the issues appearing more and more in newspapers and being talked about in the medical community is the long waiting lists of patients needing non-emergency operations. Waits of five and six years for operations for varicose veins for instance, are not uncommon. "It means people have to suffer a lot longer," Thistlewaite said.

A. H. Grabham, a BMA official, told doctors at their Manchester meeting it would be misleading to imply there had been widespread major cuts in the NHS (National Health Service) or that the service was falling apart.

However, he said it remained a fact that many patients - particularly the elderly and the chronic sick - received inadequate care from the NHS.

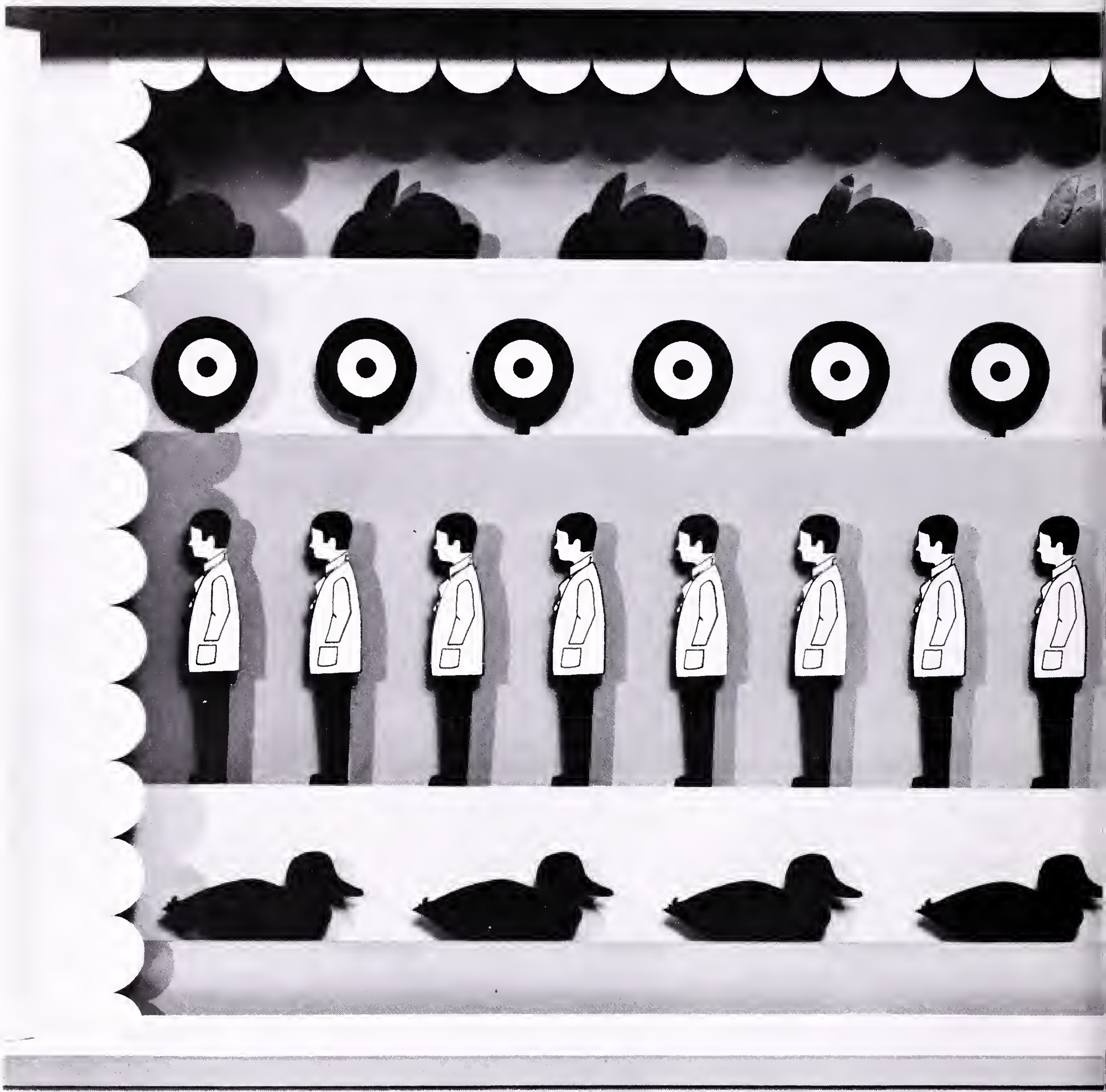
"So the gap between what the profession could do for patients and what it actually did was steadily widening," he said. "Too many patients waited far too long for outpatient consultation. Far too many patients waited far too long for necessary operations and far too often the general practioner was having to cover as best he could for the deficiencies in the hospital service."

And while there are delays, the BMA denies any rationing is going on.

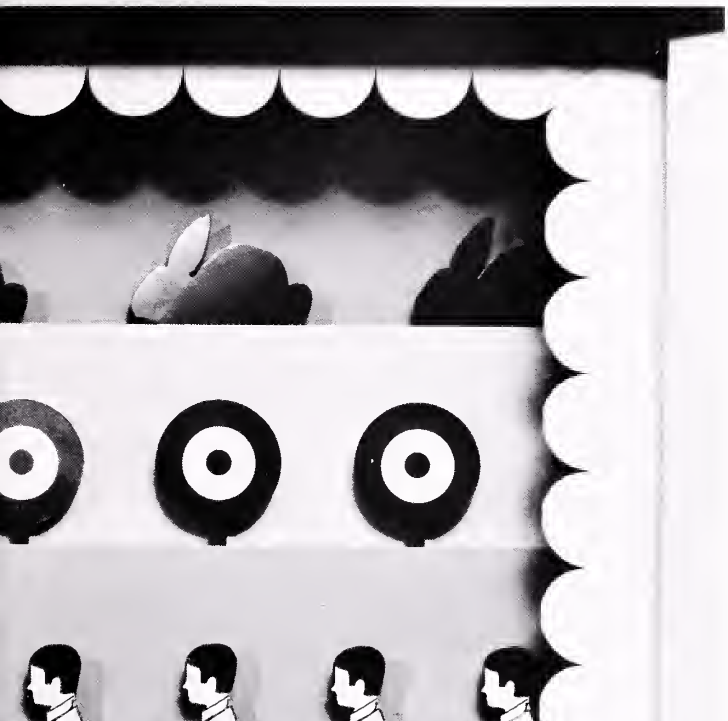
"There are long delays, yes," Thistlewaite said. "But there is no

Continued on page 512

If you become the target of a



©1983 MPMLC



professional liability claim...

You will be glad you have Michigan Physicians.

Michigan Physicians has been solving complex medical professional liability problems since 1976. With the state's largest and most experienced claims staff, Michigan Physicians works with you to resolve claims (and incidents) that most physicians have never faced in their careers.

In a changing legal environment, you need the best coverage you can buy because the risk of a professional liability claim is becoming greater every day.

For a confidential rate quotation and more information about Michigan's leading physician-owned insurance company, call or write the office in your area.

Michigan Physicians
Mutual Liability Company

1305 Abbott Road
East Lansing, MI 48823
(517) 351-1150
(800) 292-1926

6735 Telegraph Road
Suite 205
Birmingham, MI 48010
(313) 647-5550

Endorsed by the Michigan State Medical Society

BRITISH/Continued from page 509

rationing. It's just not true that rationing is going on."

As one way around the long waiting lists, there is a growth in numbers of private doctors and surgeons. More and more middle income persons are joining such insurance organizations as BUPA that will finance operations and/or treatments by private doctors and hospitals where medical aid is readily available. About three million persons in Britain now belong to BUPA.

In large print on the brochure describing BUPA's benefits is - "First and foremost, I want to be able to go into the hospital without delay."

Alternative medicine

Another issue facing the BMA is the use of "alternative" medicine as valid medical treatment. It was in 1983 that Prince Charles, serving as president of the BMA, stunned members by coming out in support of alternative medicine in his inaugural address.

"The whole imposing edifice of modern medicine, for all its breathtaking success, is like the celebrated Tower of Pisa. It's slightly off balance," he told the doctors. "It is frightening how dependent upon drugs we are becoming and how easy it is for doctors to prescribe them as the universal panacea for our ills. Wonderful as many of them are, it should still be more widely stressed by doctors that the health of human beings is so often determined by their behavior, their food and the nature of their environment."

In a series of interviews this summer with the press, Prince Charles maintained that diet, the love and support of friends, plus the power of the mind can cure even terminally ill cancer patients.

He outlined his personal fitness regime, which included plenty of exercise and vegetarian meals. It was also reported he believes in psychic experiences and has his dreams analyzed.

All in all, he wants the profession to look more closely at such things as acupuncture, herbalism and meditation as a means of curing illnesses.

"Looking at the whole person has been neglected for some time, but I think people are beginning to realize how important it is," he said. "They're increasingly fed up with being treated as machines."

In response to the Prince's views, the BMA set up a study committee to consider the feasibility and possible methods of assessing the value of alternative therapies "whether used alone or to complement other treatments."

And so, after 152 years, the BMA finds itself grappling with complex medical issues in a world where the days of doctors simply dispensing medication and advice are as antiquated as a suit of armor.

TAKE A BREAK EACH WEDNESDAY

with **Health Care News**, the most accurate, reliable, and complete way to keep abreast of health care regulations, legislation, mergers, moves, negotiations, people, continuing education, and job opportunities. We give you the news you need to know **52 times a year for only $11. $20 for 2 years & a free coffee cup.**

Health Care News
Your FREE HCN Coffee Cup!

Subscribe now. Limited time only.

Health Care News

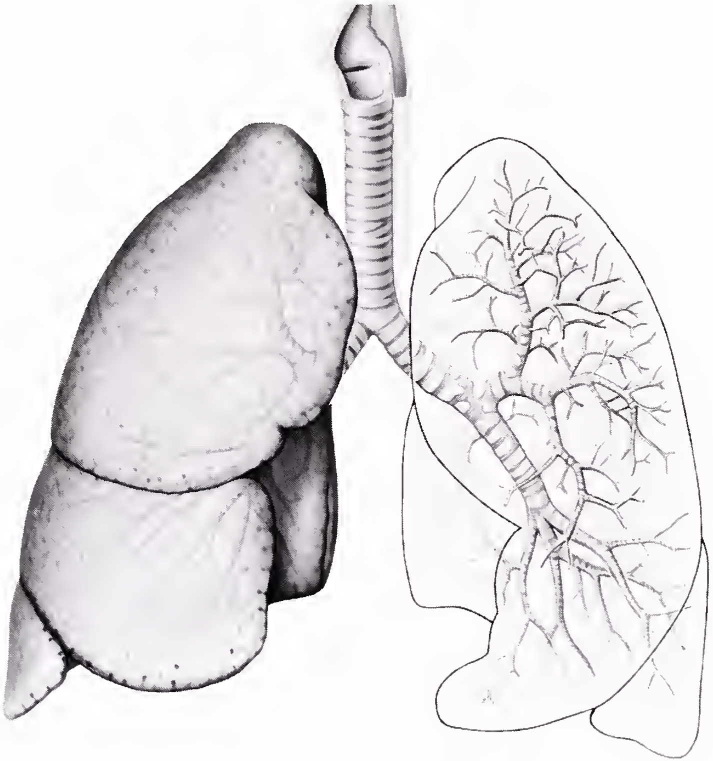
SERVING MICHIGAN'S HEALTH CARE PROFESSIONALS

☐ Payment Enclosed
☐ New
☐ Renewal
☐ Bill me— $1.50 additional
☐ Bill firm—$1.50 additional
☐ Visa ☐ Mastercard

Firm Name (if applicable) ____
Name ____
Address ____
City/State/Zip ____
Interbank # ____ Exp. Date ____
Signature ____
Drivers License Number ____

5440 Cass Avenue • Detroit, Michigan 48202 • (Phone (313) 831-3323
Telephone Orders Accepted

Consider the causative organisms...



Ceclor®
cefaclor
250-mg Pulvules® t.i.d.

offers effectiveness against the major causes of bacterial bronchitis

H. influenzae **(ampicillin-susceptible), *H. influenzae*** **(ampicillin-resistant), *S. pneumoniae*, *S. pyogenes***

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile* Other causes of colitis should be ruled out

Precautions: *General Precautions* — If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e g , pressor amines, antihistamines, or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor® (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively Trace amounts were detected at one hour The effect on nursing infants is not known Caution should be exercised when Ceclor is administered to a nursing woman

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70)

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor Such reactions have been reported more frequently in children than in adults Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information

© 1984 ELI LILLY AND COMPANY

Lilly

400441

Additional information available to the profession on request from
Eli Lilly and Company
Indianapolis, Indiana 46285

Eli Lilly Industries, Inc
Carolina, Puerto Rico 00630

By Carole Eberly

'Phlegmatic' British rarely sue for medical malpractice

London, England—Compared with their US counterparts, British physicians are living in a malpractice paradise.

"The worst thing in Britain is to break a queue (cut in line)," said Doctor Sumer Verma, MD, an East Lansing physician on sabbatical at Cambridge University. "That you will get jumped all over for. But apart from that, the British hold doctors in very high esteem and they are not generally litiginous."

He assesses Britons as a phlegmatic group of people willing to accept the risks of living. Consequently, malpractice suits are uncommon.

$260 award

Every now and then a malpractice case appears in one of the London newspapers. But the huge settlements reported in the US are unheard of. One person writing a letter in the London Times compared the large US settlements to winning a lottery.

Awards for cases making the newspapers range from $500 to about $5,000, with awards of more than $100,000 being rare exceptions.

In one case a 17-year-old sustained a laceration of his hand after a fall off a moped. After a GP probed and cleaned the wound, a nurse sutured it. After eight months he complained of pains in his hand. He was referred to an orthopedic surgeon who x-rayed the hand and found a foreign body, probably glass. The boy was put on the waiting list for four months before the glass was removed. During this time his employers refused to permit him to work. As a result, he lost about $260 in wages, after allowing for benefits paid him. His father claimed against the hospital for his lost earnings, but made no allegation of negligence against the first doctor.

The boy was awarded $260.

The Medical Defence Union, a London-based worldwide organization, handles malpractice suits and payments for 105,000 physicians and dentists around the globe. According to figures released for the latest year available, 1982, claims paid around the world totaled about $12 million.

The lower payments are reflected in the annual fee of about $330 in Great Britain for protection against lawsuits. For that money, a physician or dentist is guaranteed 24-hour access to phone banks where advice is given on how to handle potential problems. If a suit is filed, the Union handles the defense and paperwork through the legal process. If a claim is upheld, the Union assists in payment.

"Our whole emphasis is on prevention," said Doctor Brooke Barnett, secretary of the Union. "If a doctor sees a problem coming on, he doesn't have to struggle on with it. Instead, we urge him to ring us for advice.

"If it works out in the end that a patient has to be paid, we jolly well pay the person."

The Union began 99 years ago because of two incidents involving physicians. The first involved a doctor who went bankrupt trying to prove he did not cause the death of a child who had diphtheria. Although he was found innocent, the court costs broke him.

The second case involved a doctor who actually served eight months of a two-year sentence guilty of attempted criminal assault on a female patient. However, he was granted a pardon when it became apparent there was sufficient doubt about the evidence.

Doctors, dentists

And so "five gentlemen and two solicitors" set up the nonprofit Union. Now the organization is run entirely by 15 doctors and dentists for their colleagues.

Although headquartered in London, the Union has other major branches in Sydney, Athens and Pretoria. Membership is open to all doctors and dentists throughout the world, except those in the US.

Considering that malpractice insurance in the US for physicians can approach hundreds of thousands of dollars, how is the Union able to provide such inexpensive protection?

"In the first place, we are not an insurance company," said Doctor Barnett.

Since there is no money going to a privately owned insurance company, Doctor Barnett said all funds are funnelled into the organization for its members.

And, although the Union refuses to release the exact number of suits filed in Britain and the average claim paid, the medical community readily admits very few persons sue doctors in Britain.

In addition, because the British have free health care, it's been

---

Ms. Eberly is a Lansing-area freelancer writer.

“And so five gentlemen and two solicitors set up the non-profit Medical Defence Union.”

suggested that people just are not anxious to sue over something that is free.

“Although society has become more consumer oriented, Britons nevertheless have not staked a lot of money in direct payments to doctors,” said Tony Thistlewaite, spokesman for the British Medical Association.

However, Doctor Barnett said “no one really knows” why there are fewer lawsuits for less money.

“It’s been suggested that since Britain does not have a contingency fee system for lawyers, that may be the reason,” he said. “But there’s no definite proof.”

He added that Britons could get by the high cost of litigation through a legal aid system that’s either free or charges a small fee. He said most anyone could receive help “since there is a generous income limit on who can get help.”

One person who used the system owned a stable of horses, he said.

“More than likely it’s your high standard of living in the US,” he offered. “In the US if a millionaire is negligently damaged, the award is going to be much higher if you figure how much he would have earned in a lifetime. Here, our wages are much lower.”

School teachers, for example, earn about $11,000 and secretaries about $8,000.

Doctor Barnett said the number of malpractice suits has incresed in the last five years from two to every thousand of its doctors to about four. He said it has now leveled off at that number after showing a steady increase.

LETTERS/Continued from page 489

to 15 years for running down and mangling a pedestrian, leaving three children motherless. (Twice before he had been found guilty of drunk driving, and merely fined.)

"I never blew a turn at the ballot box," he claimed. "I even voted in school board elections. I'm an alcoholic but I'm also a hard-working, honest, patriotic American. And I'm up on voting because I'm down on lousy deals like Watergate, Debategate and Scandalgates of all kinds. I know that if enough Americans attend to patriotic duty, someday we'll send a president to Washington who will Fumigate."

I found a 39-year-old bandit busy at a sewing machine in the garment shop. He is doing "all day" (natural life with no provision for parole). "Sewing, huh?" I asked idiotically.

He finished a seam, shut off the machine, rose, and replied, "Nope. I'm reaping."

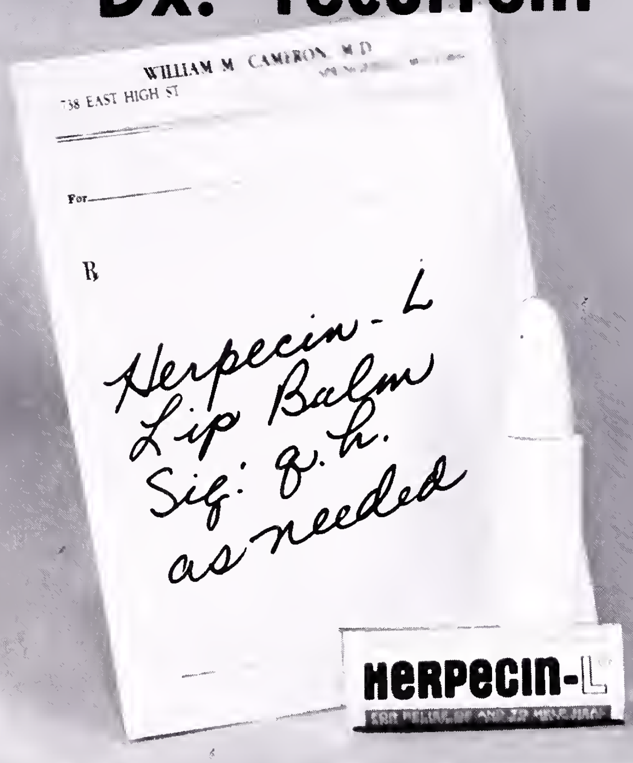
A chuckle or two later he responded to the voting questions. "My dad was a strict three-D man. Discpline. Duty. Democracy. Our house was run that way. Any family crisis that could be voted on called for balloting. Me, Mom and Dad, one brother and three sisters all toed the three-D line.

"Dad believed that no democracy could survive without the other two Ds, and that all three Ds must start and flourish in the home. So, naturally, it bothers me that part of my punishment is being unable to vote. I never had a chance to vote in a public election." (At 19, "high on pot and what not," a month after his father died, he had held up a jewelry store, wounded a cashier and killed the proprietor.)

As for myself, I seem to be a fixture in the chronic misfit category. Now 72, I have served 33 years in one Conville or another—nearly all for counterfeiting, and cashing, checks. (For seven months in 1920, when I was nine years old, my father had me on the street cashing his bum checks. All told, dad spend 22 hours in jail.) But I rarely neglected voting when free and I have high hopes of voting again (in 1988). Meanwhile, the burglar's words keep echoing to enchance my contention that, on either side of the walls of Conville, USA, it is invariably the non-voters who are most addicted to griping. They seem unable to understand that the only shots heard 'round the political world are the wee small voices of voters at the polls.

In the end, in a strict patriotic sense, I feel that nothing is worse than losing one's right to vote in Conville, USA. Except what occurs in your city, town or village, where each and every registered American citizen may vote and "Take pride in the privilege." . . . And you don't.

Pete Simer
Jackson



Dx: recurrent herpes labialis

"Herpecin-L Lip Balm is **the treatment of choice** for peri-oral *herpes*." GP, New York

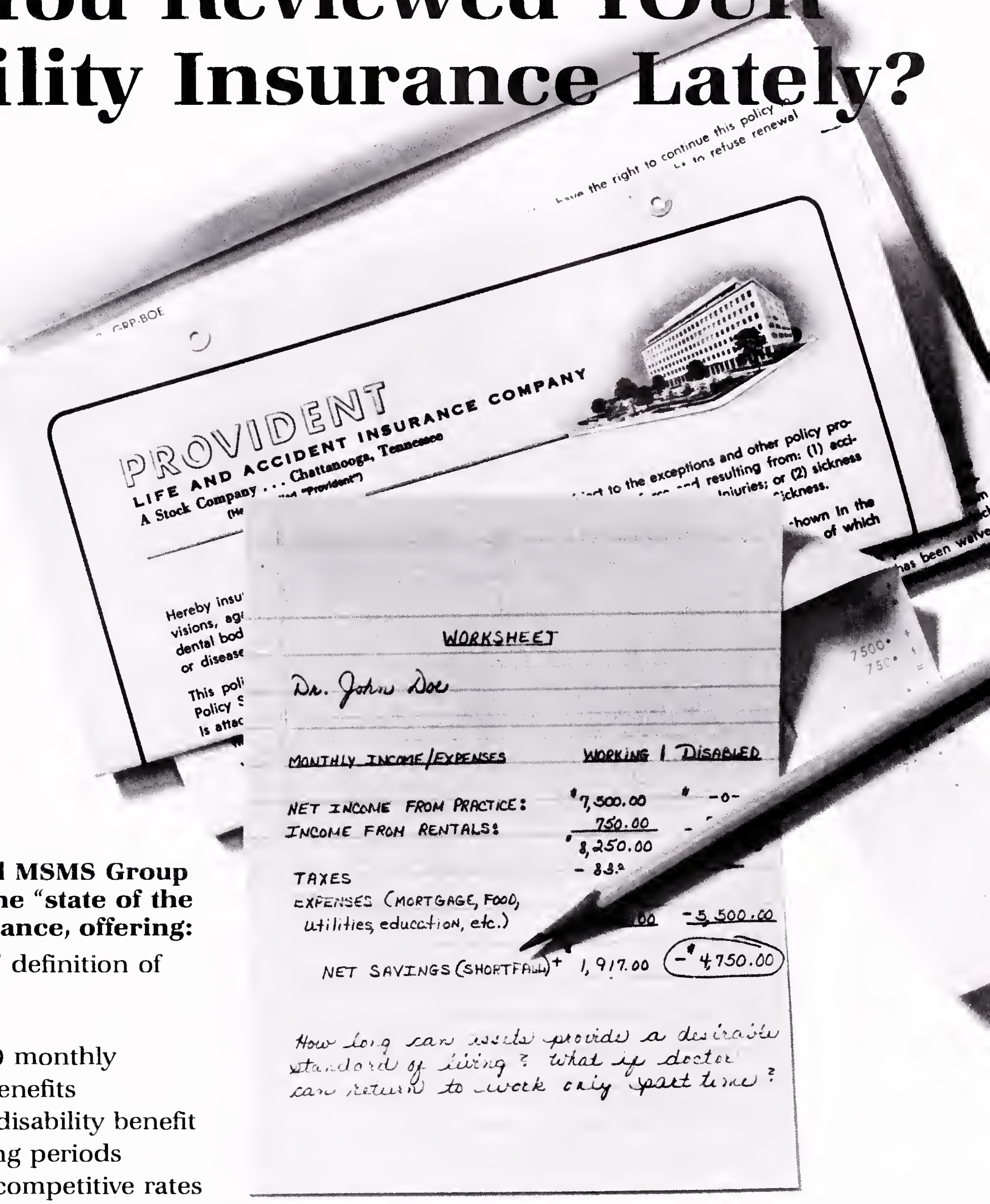
"In the management of *herpes labialis*, Herpecin-L is a **conservative approach with low risk / high benefit.**" Derm., Miami

"Staff and patients find Herpecin-L remarkably **effective**." Derm., New Orleans

OTC. See *P.D.R.* for information.
For trade packages to make your own clinical evaluation, write:
Campbell Laboratories Inc.
P.O. Box 812-M, FDR, NY, NY 10150

In Michigan, "HERPECIN-L" Cold Sore Lip Balm is available at all *Muir, Perry, Revco* and *Sentry Drug Stores* and other select pharmacies.

Have You Reviewed YOUR Disability Insurance Lately?



PROVIDENT
LIFE AND ACCIDENT INSURANCE COMPANY
A Stock Company . . . Chattanooga, Tennessee

WORKSHEET

Dr. John Doe

MONTHLY INCOME/EXPENSES	WORKING	DISABLED
NET INCOME FROM PRACTICE:	$7,500.00	$ -0-
INCOME FROM RENTALS:	750.00	
	$8,250.00	
TAXES	- 83…	
EXPENSES (MORTGAGE, FOOD, utilities, education, etc.)	…00	-5,500.00
NET SAVINGS (SHORTFALL)	+ 1,917.00	-$4,750.00

How long can assets provide a desirable standard of living? What if doctor can return to work only part time?

The new, improved MSMS Group Disability plan is the "state of the art" in group insurance, offering:

"Your own specialty" definition of disability
Lifetime benefits
Benefits up to $2,500 monthly
Residual disability benefits
Waiver of premium disability benefit
30 and 90 day waiting periods
Quality coverage at competitive rates
Conversion guarantee

Call or write us today for a review of your coverage and further information about our plans!

This plan is underwritten by Provident Life & Accident Insurance Company, Chattanooga, Tennessee.

Visit us at Exhibit Booth #106 during the MSMS Annual Scientific Meeting.

Stratton-Cheeseman & Associates, Inc.

1305 Abbott Road
P.O. Box 1563
East Lansing, Michigan 48823
Call Toll Free: 1-800-292-1966

By Frank B. Walker II, MD

Patient often forgotten in health care equation

Frank B. Walker, II, MD, pathologist, is the 101st president of the Wayne County Medical Society. He was installed during ceremonies June 9. Following are excerpts from his installation address delivered at the annual business meeting of the WCMS June 27. Doctor Walker's grandfather (F. B. Walker) was WCMS President in 1915, and his grandfather's cousin (H. O. Walker), was WCMS President in 1911-12. H. O. Walker was the founder of Wayne State University School of Medicine.

The environment of medicine is both frightening and challenging.

Physician manpower, competition, access, cost and quality of care; professional liability and risk management; hospital-physician relationships; the public image of physicians; government regulation of the health care system; business, labor and consumer interests in health care costs— these are just some of the issues that will require continued aggressive physician input and monitoring.

I have been fortunate in being a member of the AMA Council on Long-Range Planning and Development, which has studied the structual and role changes in the medical "environment" over the past several years.

Differences blurred

The major elements of the health sector — physicians, hospitals and health insurers — are undergoing significant structural change. One aspect of this trend is that the distinction between the major health sectors is becoming blurred. Medical practice has become more highly integrated with other types of health care institutions, private practice physicians are beginning to compete directly with health care institutions for patients, and businesses are becoming the carriers for the health insurance of their employees.

These structural changes in the health care sector have a number

Continued on page 520

$EMINAR$

*FINANCIAL SEMINARS FOR MEDICAL PROFESSIONALS

1984-85 SERIES BY WORLDWIDE FINANCIAL SEMINARS, INC.

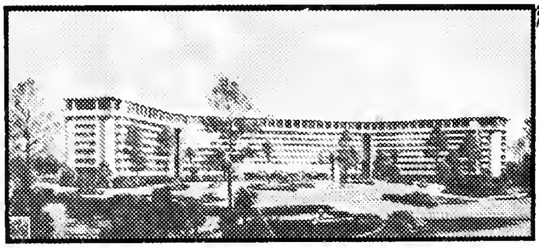
Seminars held in **Orlando, Florida at the new, luxurious Hilton at the **Walt Disney World** Village Hotel Plaza (special Seminar room rate).

Two full Thursday and Friday morning sessions throughout the year. Pick your own dates.

FOR SEMINAR INFORMATION, WRITE OR CALL *COLLECT;*
The Benn Group,
1118 Knights Place,
Lakeland, FL 33803, (813) 646-3892

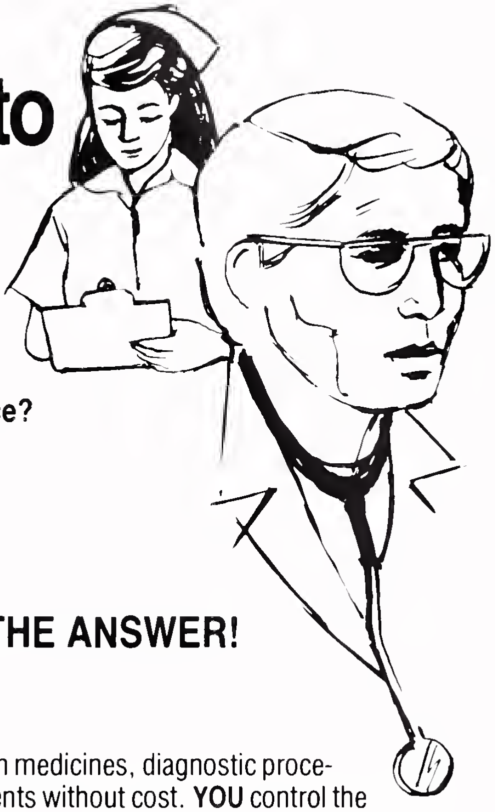
**The financial Seminar program is designed to comply with Federal tax law regarding tax deductibility.*

Staff comprised of highly qualified investment, financial planning, managed account specialists/authors from leading international investment firm.



***Year-round Area Attractions — Walt Disney World • Sea World • Cape Canaveral • Beaches • Golf • Tennis • Swimming • Deep Sea Fishing*

Are you ready to give up:



- Paying overhead?
- Managing office staff?
- Running a collection agency?
- Shelling out for malpractice insurance?
- Being constantly "on call?"
- Hassling with medical insurance companies?
- Marketing your services?

NAVY MEDICINE COULD BE THE ANSWER!

Enjoy status as a Doctor **and** a Naval Officer.

Professional care: the best that can be provided in medicines, diagnostic procedures and equipment. All available to your patients without cost. **YOU** control the care you provide.

Professional growth: specialty training, continuing medical education conferences and postgraduate education are available—all costs paid. Unique opportunities exist in aerospace and submarine medicine.

Professional support: most paperwork is handled by administrative staff, leaving you free to practice medicine. Your medical team is made up of other physicians and Nurse Corps officers who share patient load with you. When off duty, **your time is your own.**

Professional rewards: after you subtract insurance, other overhead and administrative costs that now come out of your pocket, you'll find Navy Physician salary to be comparable. Fringe benefits let you keep even more of what you earn. **Plus**, you get **30 days paid vacation** each year to enjoy it.

A lot more: including an unbeatable retirement program, full medical and dental coverage, travel opportunities and much more freedom than you've imagined.

You may find this is the practice that's perfect for you. Call 1-800-922-1702

Professional
INSTALLMENT LOANS

$15,000
TO
$90,000

Decision In
24 to 48 Hours!

**Same-Day Answer
to Applications
Received By Express Mail**

- Deal Directly With Lender
- Deferred Payment Plans
- No Prepayment Penalty
- No Restriction on Use of Funds For:
  Investments
  Payment of Taxes
  Debt Consolidation
  Tax Shelters
  Pension Plan Contributions

Ask for Tom Todd

**CALL TOLL FREE:
800-423-5025**

**Serving The Medical
Profession Since 1966**

**WOODSIDE
CAPITAL
CORP.**

National Headquarters
Woodside Capital Building
21424 Ventura Boulevard
Woodland Hills, California 91364

of potential implications of great importance and concern for all of us. Among these implications should be included the following:

- The nature of competition in the physician sector will continue to change — (there will be) increased concern over "fair" competition, advertising, marketing and commercialism in medicine,
- questions about the relationship of business decisions and medical decisions are likely to emerge — (there may be) constraints on the medical prerogatives of physicians,
- questions also may arise about the role of profit in medicine,
- the patient/physician relationship will become of increasing concern as more and more alternative delivery systems emerge.
- the services physicians need from organized medicine may change — negotiating and management techniques may have to be emphasized more than in the past,
- the issue of physician access to hospital facilities will intensify,
- the role of the medical staff in the hospital is likely to continue to be an issue of concern.
- concerns over the hospital/physician relationship will increase, with conflict over the corporate practice of medicine.
- the funding and "mix" of residency training programs is likely to become an issue — because of potential decreasing governmental or third-party support and increasing "for-profit" health care institutions.
- the percentage of health expenditures paid out-of-pocket by the typical patient is likely to increase.
- the type of insurance coverage for physicians' services could change.
- physicians are likely to be faced with increasing complexity in explaining to patients their out-of-pocket financial obligations for health care charges and in securing reimbursement from patients or patients' insurance companies.
- physicians may find that some patients are choosing inadequate or inappropriate health insurance coverage for their particular situation.
- regulation of business self-insured plans is likely to become an issue,
- professional liability concerns are likely to intensify with the increasing complexity and implementation of these structural changes.

These structural changes will further increase competitive pressures on physicians. An increasing proportion of physicians is likely to become employees of health care institutions. Pressures will intensify on physicians to consider economic factors in making medical decisions. We should all expect increasing concern of physicians over these changes in their environment.

Individual loyalty

Despite the changes which have already occurred and will be of increasing concern in the days ahead, we must retain individual loyalty to the forgotten person in this equation — the patient.

Our job now is to go forward with these issues and concerns, and begin to act rather than react. We must regain our professional esteem, adhere to professional ethical standards, reverse the decline in our public image, remain loyal to our patients, and once again practice the "art" of medicine.

"I don't feel very good about our government."

Laboratory Facilities:

Advance Medical & Research Center, Inc. laboratory services and operations have been designed to meet the growing needs of Michigan's medical community. In addition to our main laboratory, located in Pontiac, we have client service centers and branch laboratories in most major outstate communities.

ADVANCE MEDICAL & RESEARCH CENTER, INC.

1270 Doris Rd. • Pontiac, Michigan 48057 • (313) 373-9120

Branches: Allen Park, Alpena, East Jordan, Flint,
Grand Rapids, Kalamazoo, Lansing, Monroe, Traverse City

Serving the medical profession since 1963

①

By Nancy Cranda

PROJECT MEDVOTE: AMA gets out vote

On Nov. 6, American voters will elect the President, 33 senators, the entire House of Representatives, 13 governors, and thousands of state and local officials.

These elected officials not only will shape the direction of the nation, but also, given the pattern of recent years, will help determine the way medicine is practiced.

In order to have any influence with these officials, it is essential that physicians, spouses, and eligible members of the medical family vote. The 350,000 AMA and AMA Auxiliary members, plus their families and employees, equal one million eligible voters . . . and that equals voting power!

However, not every one of the one million people is registered to vote, and if they are not registered, they can't vote. That's why the AMA and the AMA Auxiliary have conducted a program this fall called "Project MEDVOTE." The purpose has been to identify unregistered voters in the medical family, to get them registered and then to remind them to vote in November.

The MSMS Auxiliary is coordinating the project in Michigan and is using existing communications networks of county auxiliaries. Most counties have either a phone call or a post card system for monthly meeting information and reservations. We are passing information on voter registration and reminders to vote through these networks. We also are using newsletters and bulletins. We have encouraged each county auxiliary to identify physicians and spouses who are not registered and to urge them to do so.

Voters had to be registered in Michigan 30 days prior to election (by October 6). That effort is now behind us. Now we are concentrating our efforts to get our people to the polls. It is a shocking situation when educated, responsible citizens such as physicians and their family members are not registered to vote. Some figures place the percentage of unregistered physicians/spouses at 40! Here in Michigan we think that figure is closer to 20 to 30 percent.

It is equally disturbing that many physicians and their spouses, even though registered do not vote.

We ourselves and the rest of our communities look to us to lead in performing our civic duties. Let's all get out and vote November 6!

Mrs. Crandall, of Muskegon, is MSMS/A president.

Proposal C crucial issue

An important issue requiring every physician's vote is that fostered by Proposal C on the November ballot. Should the proposal pass, allocations by the state could be subject to voter approval before expenditure. MSMS observers feel passage of the proposal could tie government's hands to an extreme degree, causing costly delays and confusion in government functions.

Proposal C

A proposal to amend Article 9, Sections 1 and 2 of the Constitution relating to taxes, other revenues and voter or legislative approval of same.

The proposed amendment would:

1. Prohibit changes in the base or rate of any state or local tax which would increase its revenue yield, or adoption of new taxes, unless approved by voters.

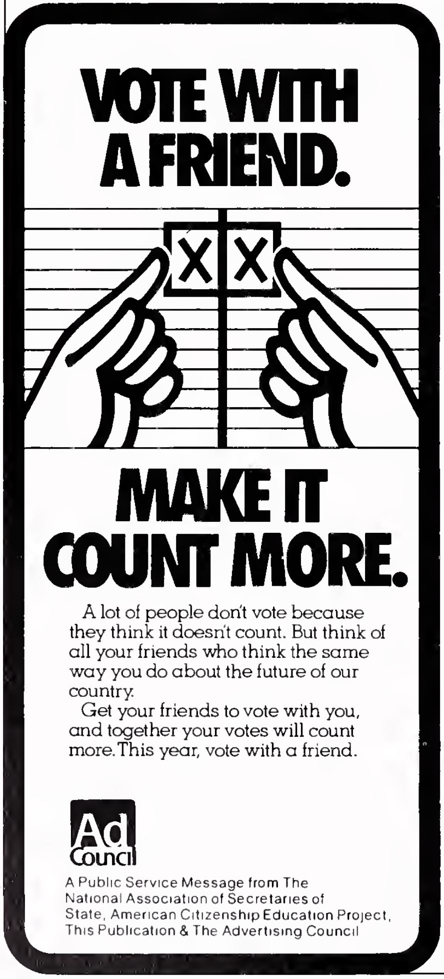
2. Make void 90 days after the adoption of amendment:

a. new or increased rate or base of state or local taxes since 12/31/81 unless/until approved by voters;

b. new or increased license user or permit fees since 12/31/81 unless/until approved by voters or 4/5 vote of legislative body adopting same.

3. Limit nonresident local political subdivision income tax to 1/2 of 1%.

4. Require tax proposals to state purpose, total anticipated amount and expiration date.


VOTE WITH A FRIEND.
MAKE IT COUNT MORE.
Ad Council

A lot of people don't vote because they think it doesn't count. But think of all your friends who think the same way you do about the future of our country.
Get your friends to vote with you, and together your votes will count more. This year, vote with a friend.

A Public Service Message from The National Association of Secretaries of State, American Citizenship Education Project, This Publication & The Advertising Council

BALANCED CALCIUM CHANNEL BLOCKADE!

CARDIZEM®
(diltiazem HCl)
balances
potent
coronary
vasodilation
with a low
incidence of
side effects

Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:

1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P < .005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

Please see full prescribing information on following page.

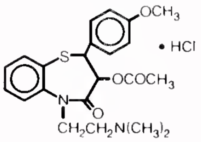
2/84

PROFESSIONAL USE INFORMATION

cardizem
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy)-5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+)-cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral/LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 4/1/84

Another patient benefit product from
PHARMACEUTICAL DIVISION
MARION
LABORATORIES, INC.
KANSAS CITY, MISSOURI 64137

High quality CME courses bring 'em back to Scientific Meeting

There's a reason why the MSMS Annual Scientific Meeting draws Michigan physicians every year to the Hyatt Regency Dearborn.

The reason is the high quality of the courses offered, from the current import of the subjects chosen, through the up to date information delivered, to the expertness of the speakers.

And this year's event, planned Nov. 13-14-15, is of the highest quality ever, according to MSMS members' comments.

The 55 half day category I courses offer a physician a chance to earn a total of 18 credits toward relicensure, and are planned to be of value to both specialists and generalists.

"Art of Medicine"

Annual Scientific Meeting Chairman David R. Rovner, MD, East Lansing, and his planning committee have worked hard this year to emphasize clinical courses, with the aim of helping Michigan physicians improve the "art of medicine." That phrase is the theme of the promotional advertising which has appeared in letters, posters, ads and articles.

MSMS members have a wide range of topics from which to choose. There are the critical care subjects such as "Management of Office Emergencies," "Strokes: New Help, New Hope," "Diarrhea: A Diagnostic Dilemma," "Examination and Treatment of Non-operative Office and Sports Problems of the Upper Extremity," and "Trauma: Pathophysiological Basis of Acute Care, Reconstruction and Research."

There are updates of always important subjects such as hypertension clinical diagnostic radiology, arm pain and dysfunction, drug level monitoring as it relates to clinical medical practice, follow-up of high risk infants, diabetes, skin diseases, breast reconstruction, male infertility and impotence, and prenatal care, labor and delivery.

Courses which reflect new medical care directions include "Psychiatric Aspects of Medical Practice," "Occupational Health Concerns," "Elder Care Management, Changing Needs and Resources," "Alternative Forms of Therapy for Primary Breast Cancer," "Alzheimer's Disease: Pathogenesis, Diagnosis and Management," "Clinical Nutrition," "Controversies in Allergy," "Cholesterol and Coronary Artery Disease," "Saving Sight: Recognition and Remedies," "Initial Management of Sports Injuries," and "Medical Ethics and Malpractice: Is It Better to be Safe or Right?"

A number of courses deal with psychiatric and emotional disorders, including those entitled "Depression for Primary Care Clinicians: New Developments in 1984," "Psychiatric Aspects of Medical Practice," "Attachment Disorders in Infancy," "Tragic Events in Obstetrics and Gynecology: Coping with Bereavement and Infertility," "Anxiety States and Panic Disorders: A More Common than Thought Medical Problem," and "Behavioral Pediatrics."

A full description of each course, its director and speakers appears in the September issue of *Michigan Medicine,* and is available from Sherry Fent at MSMS headquarters (517/337-1351).

On the back side of this sheet is a registration form for the courses, which may be removed, filled out and returned to MSMS offices. The registration form also appears in the Aug. 16 *Medigram,* the September *Michigan Medicine* and the Oct. 4 *Medigram.*

Exhibit Hall

Physicians attending the 1984 meeting may browse 70 educational and service booths which will be displayed in the Grand Exhibit Hall of the Hyatt Regency Dearborn.

They will display everything from encyclopedias to computers for physicians' use, and will be staffed with experts. The luncheons for the Annual Scientific Meeting attendees will be served each noon in ten exhibit area.

In addition, the Grand Exhibit Hall will be the location for the first-ever display of poster presentations by Michigan physicians who were selected to describe recent personal experiences in medicine.

Doctor Rovner and his committee selected 16 of these poster presentations for the Annual Scientific Meeting. They will be displayed Wednesday afternoon and evening, Nov. 14, accompanied by a wine and cheese reception.

The Hyatt Regency Dearborn is the excellent facility which has housed the MSMS Annual Scientific Meeting for all of its eight years. It features the automatic "people mover" transportation to the Fairlane Center shopping mall, and is just around the corner from the Greenfield Village/Henry Ford Museum complex.

Prices for the Annual Scientific Meeting courses are the same as those of 1983 ($6 per credit hour for members, $12 for nonmembers, $3 for retired members and $5 per course for residents).

Michigan physicians cannot afford to pass up this CME bargain!

Annual Scientific Meeting registration form next page ⟶

PLEASE SEND ENTIRE PAGE WITH CHECK

1984 MSMS Annual Scientific Meeting, Hyatt Regency Dearborn Registration form for Category I CME Courses

*All courses are approved for AAFP Prescribed Credit *EXCEPT* those marked with an asterisk.

TUESDAY MORNING, NOV. 13

(8:30 to Noon, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Basic Cardiac Life Support
____ Brain Ischemia: Injury and Therapy
____ Conservative Management of Early Breast Cancer
____ Depression for Primary Care Clinicians: New Developments in 1984
____ Management of Office Emergencies
____ Occupational Health Concerns: Update 1984
____ Psychiatric Aspects of Medical Practice
____ Strokes: New Help, New Hope
____ Use, Abuse and Interpretation of Renal Assessment Tests

TUESDAY AFTERNOON, NOV. 13

(1:30 to 5:00, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Advanced Cardiac Life Support Recertification
____ Attachment Disorders In Infancy
____ Elder Care Management: Changing Needs and Resources
____ Everything You Wanted to Know About Local Anesthetics
____ Hematology
____ Modern Approach to Clinical Diagnostic Radiology
____ Neurological Problems of General Interest and Frequent Encounter
____ Non-Invasive Vascular Lab and the Primary Physician
____ Tragic Events in Obstetrics and Gynecology: Coping with Bereavement and Infertility

WEDNESDAY MORNING, NOV. 14

(8:30 to Noon, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Alternatives in Management of Primary Breast Cancer
____ Arm Pain and Dysfunction: Diagnosis and Management
____ Basic Cardiac Life Support
____ Carcinoma of the Female Reproductive Tract
____ Chest Roentgenography for the Clinician
____ Current Update on the Use of Drug Level Monitoring as it Relates to Clinical Medical Practice
____ Dermatology in Practice
____ Evaluation and Treatment of the Dizzy Patient
* ____ Follow-up of High Risk Infants: The State of the Art
____ Hypertension: Non-Pharmacological Treatment

WEDNESDAY AFTERNOON, NOV. 14

(1:30 to 5:00, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Alzheimer's Disease, Pathogenesis, Diagnosis and Management
____ Clinical Nutrition
____ Common Laryngeal Diseases in Children and Adults
____ Controversies in Allergy
____ Diabetes Update: 1984
____ Diarrhea: A Diagnostic Dilemma
____ Epilepsy in Children
____ Examination and Treatment of Non-Operative Office and Sports Problems of the Upper Extremity
____ Prenatal Care, Labor and Delivery: What's New in 1984
* ____ What's New in Dermatology

THURSDAY MORNING, NOV. 15

(8:30 to Noon, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Basic Cardiac Life Support
____ Cholesterol and Coronary Artery Disease
____ Clinical Update on Panic Disorders
____ Current Management Strategies for Headache Disorders
____ Management of Low Back Pain
____ Saving Sight: Recognition and Remedies
____ Topics in Rheumatology
____ Trauma: Pathophysiological Basis of Acute Care, Reconstruction and Research

THURSDAY AFTERNOON, NOV. 15

(1:30 to 5:00, including break)
(Write 1 in blank for first choice and 2 for second choice)

____ Behavioral Pediatrics
* ____ Breast Reconstruction: 1984
* ____ Clinical Organ Transplantation in the Eighties
____ Colonic Surveillance
____ Current Aspects of Male Infertility and Impotence
____ Diagnosis and Management of Peripheral Nerve Disorders
____ Initial Management of Sports Injuries
____ Medical Ethics and Malpractice: Is it Better to be Safe or Right?
____ Nuclear Medicine Update: 1984

The MSMS Committee on CME Programming, an organization accredited by the MSMS Committee on CME Accreditation, certifies that this activity meets the criteria for a maximum of 18 credit hours in Category I toward the requirements for Michigan relicensure and of the Physician Recognition Award of the AMA, provided it is completed as designed.

Please check the courses you wish to attend. In each case, *please indicate a second choice* should the first choice already be filled. Maximum attendance figures have been set for each course, depending on room size.

Send this entire page with your check. Confirmation of your reservation will be sent to you. Your course credentials, badge, and luncheon tickets must be picked up at the MSMS Registration Desk in the Great Lakes Exhibit Center.

Physicians must make their own hotel reservations prior to 10/18/84 direct with the Hyatt Regency Dearborn, Fairlane Town Center, Dearborn, MI 48126, 313/593-1234. In order to take advantage of the special conference rates, please mention that you will be attending the MSMS Annual Scientific Meeting.

See room reservation card for details about how you can win a complimentary room and dinner for two at Giulio's by making your room reservations early!

Name ____________________
(please print) (first) (initial) (last)

Street ____________________

City, State ____________ Zip ________ Phone ________

MSMS Member: Yes ____ No ____ Resident ____ Specialty ________ Other ________

Tuition Schedule for Courses:

MSMS members: $6 per credit hour, or $18 for each half-day course
MSMS members with "retired status" pay half the regular course fee
Non-members: $12 per credit hour, or $36 for each half-day course
Residents: $5 PER COURSE (Does Not Include Lunch)

A deli sandwich lunch will be provided at no extra charge. Advance notice is requested so MSMS can give an accurate guarantee. Please indicate which days you want a lunch ticket.

- Tuesday lunch ________ Wednesday lunch ________ Thursday lunch ________
- Indicate total number of half-day courses:
  ____ x $18 (members) $ ________
  ____ x $ 9 (retired) $ ________
  ____ x $36 (non-members) $ ________
  ____ x $ 5 (residents) $ ________
- Please enroll me in the MSMS/PSG seminar, being held from 7-9 p.m. (Physicians' guests are free.)
  Tue. 11/13 "Personal Financial Planning and Tax Advantaged Investing" ____ x ($18 fee) $ ________

TOTAL $ ________

Make checks payable to MSMS and mail to MSMS, Box 950, East Lansing, MI 48823.

Competence counts

Hurley Medical Center photo

In selecting a doctor, 74 percent of Americans consider competence, not cost.

Competent doctors remain the key to health. But competence isn't immunity to litigation.

Consider our competence – and our professional liability protection and strong-defense philosophy.

We defend you against non-meritorious claims. We won't settle a claim without your approval or merely to cut our defense cost.

PICOM
Physicians Insurance Company Of Michigan
4277 Okemos Rd., Box 1000
Okemos, Michigan 48864
(517) 349-6500
(313) 557-4845
1-800-292-1036

From One of the Oldest Medical Computer Companies in Michigan

COMPLETE MEDICAL OFFICE COMPUTER DESIGNED FOR MICHIGAN PHYSICIANS

$6300

Includes

- IBM PC XT
- Program
- Training Class

Call or Write Today

Bennethum Computer Systems, Inc.
31811 Middlebelt Rd.
Suite 202
Farmington Hills, MI 48018
313/851-3058

— Since 1968 —

Here's some background on AMA Medicare suit

The AMA has filed suit challenging the constitutionality of provisions in the Medicare Amendments passed with the Deficit Reduction Act of 1984. The following article describes the events leading up to the AMA lawsuit and the AMA's reasons for bringing suit.

On July 18, President Reagan signed the Deficit Reduction Act of 1984. It has more than 300 provisions to reduce federal spending, more than 60 of which affect Medicare and Medicaid. The AMA's intended filing of a suit in federal court involves only the provisions for a physician fee freeze; the provisions penalizing physicians who comply with the freeze but who do not sign an agreement accepting assignment in 100 percent of Medicare cases; and the provisions restricting clinical diagnostic laboratory reimbursement.

Provisions affecting patients and physicians

The law does these things:

(1) Freezes Medicare reimbursement levels for physician services from July 1, 1984, to September 30, 1985. The AMA does not question the legality of the reimbursement freeze itself.

(2) Creates two classes of physicians for Medicare reimbursement:

(A) "Participating" physicians, who agree to accept assignment for all services they provide to all Medicare patients.

(B) "Non-participating" physicians, who make no agreement.

(3) Prohibits fee increases by "non-participating" physicians, above a specified level, during the freeze.

(4) Offers incentives to physicians to sign participation agreements.

Participating physicians

The participation agreement (furnished to physicians by Medicare carriers) had to be signed and returned to the carrier by October 1, if the physician wants to participate.

A participating physician agrees to accept assignment for all services provided to all Medicare patients during the year of the agreement. That part of the law continues indefinitely, with participation agreements to be signed each October 1. It does not end when the freeze ends.

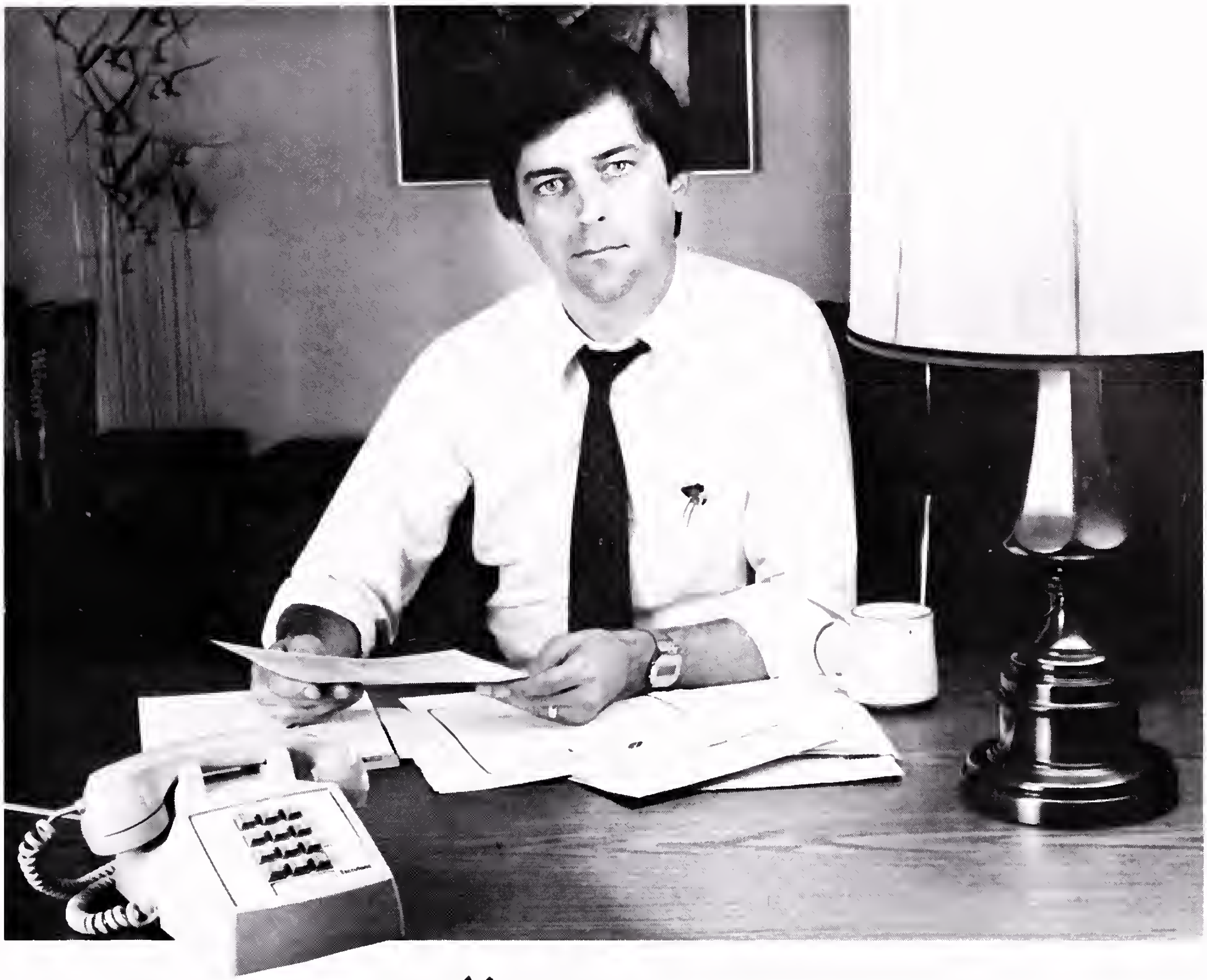
During the freeze period, a participating physician may increase fees, on paper, by billing for a higher amount. Medicare payment is based on physician's fee profile and on prevailing charges as of July 1, 1983.

However, on October 1, 1985, Medicare will recognize the increased charges, establishing a higher "profile" for participating physicians, although reimbursement cannot be higher than the prevailing charge level.

In addition to receiving a higher customary charge profile on October 1, 1985, other incentives are offered to physicians who choose to participate.

1. They will be listed in a directory showing their name, address and specialty.
2. Medicare beneficiaries will be able to get the name, addresses, telephone numbers and specialties of participating physicians from a toll-free "hot line" that each carrier will be required to maintain.
3. If a Medicare carrier can receive electronic transmission of Medicare bills, participating physicians will be able to use the system.
4. Participating physicians might (if the Secretary of HHS uses the option) receive an emblem they can display, identifying them as participating physicians.

Continued on page 530



"...Your financial security specialist is on call"

American Physicians Life believes a physician's financial security deserves specialized attention. That's why our products and services are designed with the doctor in mind. Our comprehensive portfolio of services, including life insurance, professional disability income coverage, qualified plans and tax-deferred annuities, is customized to meet your personal financial planning needs as well as those of your professional corporation.

Let American Physicians Life secure your financial planning program—that's our specialty!

Call today for the financial security specialist in your area.

AMERICAN PHYSICIANS LIFE
Bates Drive, P.O. Box 281
Pickerington, Ohio 43147
Telephone (614) 864-3900
Toll-free in Ohio, 1-800-282-7515
Toll-free outside Ohio, 1-800-742-1275

5. If Medicare beneficiaries have "Medigap" coverage, participating physicians can bill the supplemental insurance carrier for the entire Medicare-approved amount. It will pay both the Medicare and Medigap portions and be reimbursed by the Medicare carrier.

Non-participating physicians

Non-participating physicians may continue to treat Medicare beneficaries as they have been doing. They can accept assignment or not, just as before.

If they accept assignment, the percentage of claims on which they did so will be shown in a directory to be produced by Medicare carriers.

Physicians may not increase their charges to Medicare beneficiaries above the actual charges they made during the base period of April, May and June, 1984. Medicare patients who are able, and willing, cannot be asked or permitted to pay a higher fee for services than they would have paid during the base period.

If physicians do charge more, they can be fined up to $2,000 for each instance; and assessed up to twice the amount billed over the maximum allowable charge determined from the base period.

They can also be suspended from the Medicare program for up to five years. An exception is physicians who are the sole source of physician services, or of essential specialized services, in a community. In that case, only the fines and/or assessments would apply.

When the freeze is over

On October 1, 1985, Medicare customary charge profiles will be updated.

For participating physicians, the new profile will recognize normal increases in charges during the freeze period and will be at a higher level.

For non-participating physicians, the new profile will remain as it was when the freeze began 15 months earlier.

The lawsuit

The complaint to be filed by the AMA against Margaret Heckler, Secretary of HHS, argues that the law violates the rights of Medicare beneficiaries and of physicians in several ways:

1. It is possible that patients would lose their right (granted by the Medicare law) to choose the physician they want because that physician would be economically unable to continue caring for them for the amount to be paid by Medicare.

2. At the end of the freeze period, Medicare patients who stay with non-participating physicians will be reimbursed less by Medicare for the same services than patients of participating physicians. That is because the customary charge profile for participating physicians will be raised at the end of the freeze, but the profile for non-participating physicians will remain the same. Thus, Medicare's 80 percent of an approved amount will be less for patients of non-participating physicians.

That is a clear violation of the Medicare law, which guarantees equal treatment of beneficiaries regardless of their choice of physician. It is also a violation of the Fifth Amendment which prohibits the enactment of laws that impair contractual obligations of the United States.

3. The freeze itself, which prohibits non-participating physicians from increasing their charges to Medicare patients — even when those patients are able and perfectly willing to pay more — forbids physicians from freely making contracts with patients. Such restrictions do not exist against any other part of our society, or against any other element of the economy.

Timing of the case

The AMA planned to file the complaint against the law in federal district court on or before October 1 (the deadline for signing up for participation).

The AMA also planned to move for summary judgment, which means, in effect that there is no dispute as to the facts, only the legal challenge. If the motion for summary judgment is granted, there should be decision on the legal questions within months.

How physicians' services component of CPI is determined

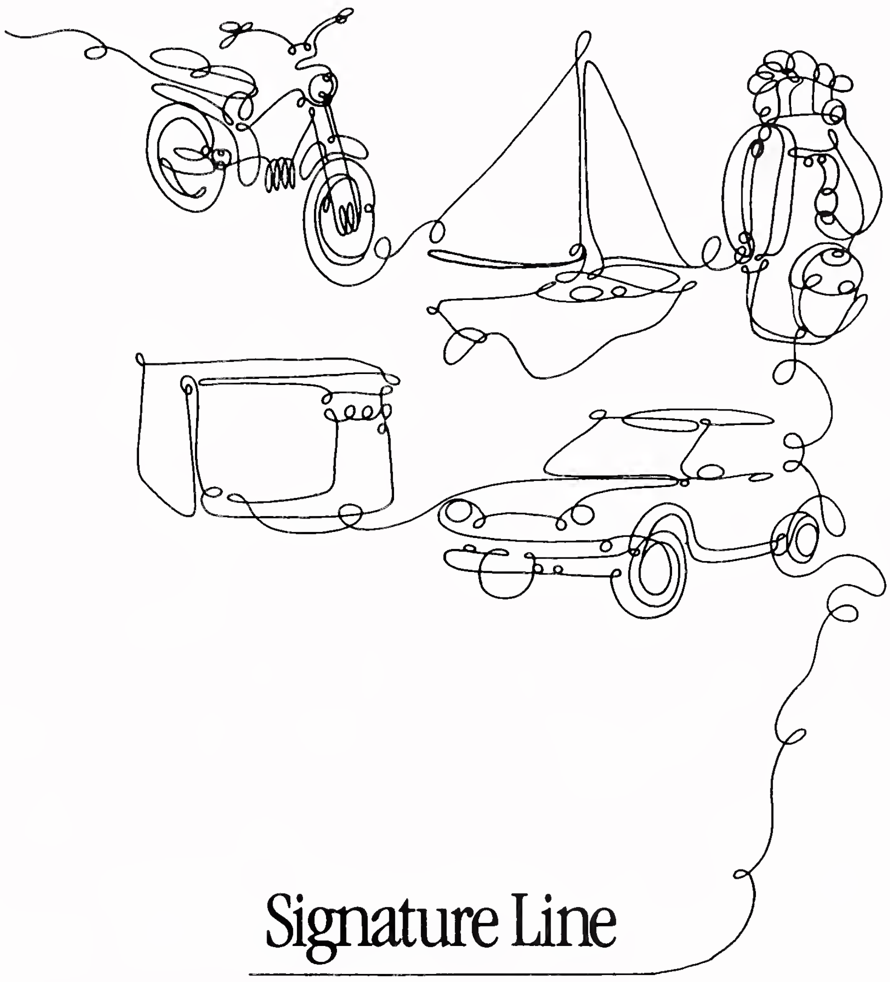
The physicians' services component of the Consumer Price Index is frequently used by the media and others as a measure of the increase in physicians fees in comparison to the increase in costs of other goods and services.

As a result of the AMA's voluntary fee freeze and the mandatory Medicare freeze recently imposed by Congress, the physicians' services component of the CPI will likely receive a great deal of attention in the future. In view of this, it is important that physicians and state, county and specialty society staffs have a better understanding of how the component is determined.

The purposes of the physicians' services component of the CPI is to measure changes in **physicians' fees paid out-of-pocket by consumers.** This has three important implications: First, the index does not deal with issues of utilization. If more people visit physicians as a result of a flu epidemic, this will have no direct effect on the index.

Second, to the degree that consumers' use of physicians' services is covered by third parties, this does not enter into the data base for construction of the price index for physician services. Third, given the out-of-pocket orientation of the survey methodology, the physicians' services component systematically under-represents services delivered by physicians who specialize in areas for which the greater part of charges are covered by insurance.

The shortest distance
between you
and your credit needs:



Signature Line

We'll lay it on the line: you file one credit application. You draw from one line of credit. You use it for anything you want. You make one payment every month or every quarter. It's just what a person of your means needs—and deserves.

We'll lay our rate on the line, too: When your balance is $1,000 or more, you'll pay 2% above prime*. That's lower than most other forms of credit. And no matter how high the prime goes, you won't pay more than 18% APR.

Let's face it. You don't need the bother of completing an application every time you want credit. Don't. Choose the shortest distance between you and your credit needs: Signature Line.

Phone 1-800-632-4453 during normal business hours.

Call Union Bank, toll-free, for a Signature-Line brochure and application.

*Signature Line interest rates are based on Union Bank's prime rate. The Annual Percentage Rate may vary from 11.5% to 18% if your average daily balance is over $1,000. If your average daily balance is $1,000 or less, the Annual Percentage Rate (APR) is 18%.

UB UNION BANK
Member FDIC
200 Ottawa N.W./Grand Rapids, MI 49503-2468

By Elmer White

Doctor Ken Rowe travels UP for public health and MSMS

Doctor Kenneth E. Rowe handles a variety of responsibilities as he ranges his wide Upper Peninsula territory.

Among these are family man, doctor, medical officer with the Michigan Department of Public Health, MSMS Board member, athletic team physician, musician, and outdoorsman.

Health problems

In his capacity as public health officer, Doctor Rowe drives 40,000 miles a year keeping tabs on his responsibilities. He tried flying to save time, but weather and difficulties in landing facilities put an end to that.

He is director of environmental health in his seven county jurisdiction in the northwestern part of the state. He oversees food service; does on-site inspections of food and sewer systems, swimming pools and beaches. He also checks septic tanks and keeps tabs on air pollution.

Doctor Rowe directs services from a van which moves from school to school supplying dental service for children whose teeth need care.

Still another of his activities is substance abuse prevention and treatment. Doctor Rowe says the biggest problem in his area is alcohol. The older population which makes up the territory is not so likely to become involved with marijuana, cocaine and heroin, he says.

Intensive outpatient programs to deal with the disease and to encourage prevention are underway in several locations in his districts.

A nursing program takes time and attention. The doctor supervises home care, a relatively new and rapidly developing aspect of health care. Doctor Rowe visits each patient or contacts physicians who see the patients for current evaluations of their need for care and the level of care they receive. Crippled children's nursing gets his attention.

The doctor also arranges clinics of specialists to keep Upper Peninsula doctors current on newest methods. Family planning services are still another responsibility, and he reports that there is little or no trouble with providing information about contraceptives.

When an epidemic occurs, Doctor Rowe is called to the scene. There are from seven to 10 such episodes each year, and it is his job to locate and correct the causes.

He keeps immunization clinics going. These involve adult screening with laboratory tests, x-ray and occult blood tests. He, himself, reads more than 50 files each week as part of routine duties.

Doctor Rowe says he spends about 20 percent of his time dealing with environmental problems. When he finds a problem, he tries hard to get those involved to comply with the law voluntarily. He has some authority, for if there is not compliance within 30 days, he is empowered to close down a facility, restaurant, bar, resort, hotel or any business which serves the public.

Ecological problems

One of his most difficult problems is connected with Torch Lake. (This is not the Torch Lake near Traverse City, but a lake with the same name which is located in Houghton County.)

Troubles began when it became clear that a high percentage of fish caught in the lake had liver tumors. Investigation showed that 90 percent of sauger and 30 percent of pike taken from Torch Lake had cancers. Since both are varieties of fish which feed on the bottom, Doctor Rowe had a lead.

He worked with technicians from Michigan Tech University to determine the cause for the tumors and to evaluate what sor of hazard the situation causes for people using the lake.

They found that four communities were using the lake,

Continued on page 535

Mr. White is a consultant to MSMS for public relations.

PRACTICES FOR SALE

GENERAL PRACTICE — Allen Park area. Good equipment and great location. Call for more information today!

INTERNAL MEDICINE — Hospital-based practice with net income of $200,000. Plenty of good equipment.

GENERAL PRACTICE — Howell area. The "only" practice in lovely downtown Howell. Easy access to major highways. Nice equipment & furniture in large office. **Very attractive terms!**

RADIOLOGY PRACTICE — Troy area. Great location. Beautiful, fully equipped with G.E. Automatic Processor. Great referrals. Terms available.

MEDICAL PRACTICE — Detroit area. Wonderful practice located in the Fisher Building. Equipment well cared for and in good condition. **Call Today!**

Professional Practice Sales, Inc.
27208 Southfield Road
Lathrup Village, Michigan 48076
HERBERT SILVERMAN, BROKER
(313) 569-7336

Motrin reduces inflammation, pain ...and price

New low price...major savings

The dramatic reduction in the price of *Motrin* Tablets means substantial savings from now on for your patients and for patients all across the country for whom *Motrin* Tablets are prescribed.

Motrin is priced lower than Clinoril, Feldene, or Naprosyn.

The price of *Motrin* Tablets to pharmacies has been reduced as much as 35%. Patients taking the average dosage should now pay less for therapy with *Motrin* Tablets than for almost any other nonsteroidal anti-inflammatory drug you prescribe... less, for example, than for Clinoril, Feldene, or Naprosyn. And, of course, all strengths of *Motrin* Tablets continue to be available by prescription only.

Please turn the page for a brief summary of prescribing information.

Motrin® 400 & 600 mg TABLETS
ibuprofen

Good medicine...good value

© 1984 The Upjohn Company

The Upjohn Company **Upjohn** Kalamazoo, Michigan 49001

Motrin® Tablets (ibuprofen)

Contraindications: Anaphylactoid reactions have occurred in individuals hypersensitive to *Motrin* Tablets or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin, iodides, or other nonsteroidal anti-inflammatory agents.

Warnings: Peptic ulceration and GI bleeding, sometimes severe, have been reported. Ulceration, perforation and bleeding may end fatally. An association has not been established. Use *Motrin* Tablets under close supervision in patients with a history of upper gastrointestinal tract disease, after consulting ADVERSE REACTIONS. In patients with active peptic ulcer and active rheumatoid arthritis, try nonulcerogenic drugs, such as gold. If *Motrin* Tablets are used, observe the patient closely for signs of ulcer perforation or GI bleeding.

Chronic studies in rats and monkeys have shown mild renal toxicity with papillary edema and necrosis. Renal papillary necrosis has rarely been shown in humans treated with *Motrin* Tablets.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue *Motrin* Tablets and the patient should have an ophthalmologic examination, including central visual fields and color vision testing.

Fluid retention and edema have been associated with *Motrin* Tablets; use with caution in patients with a history of cardiac decompensation or hypertension. In patients with renal impairment, reduced dosage may be necessary. Prospective studies of *Motrin* Tablets safety in patients with chronic renal failure have not been done.

Motrin Tablets can inhibit **platelet aggregation** and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and on anticoagulant therapy.

Patients should report signs or symptoms of **gastrointestinal ulceration** or bleeding, skin rash, weight gain, or edema.

Patients on prolonged **corticosteroid therapy** should have therapy tapered slowly when *Motrin* Tablets are added.

The antipyretic, anti-inflammatory activity of *Motrin* Tablets may mask inflammation and fever.

As with other nonsteroidal anti-inflammatory drugs, borderline elevations of liver tests may occur in up to 15% of patients. These abnormalities may progress, may remain essentially unchanged, or may be transient with continued therapy. Meaningful elevations of SGPT or SGOT (AST) occurred in controlled clinical trials in less than 1% of patients. Severe hepatic reactions, including jaundice and cases of fatal hepatitis, have been reported with ibuprofen as with other nonsteroidal anti-inflammatory drugs. If liver disease develops or if systemic manifestations occur (e.g. eosinophilia, rash, etc.), *Motrin* should be discontinued.

Drug interactions. *Aspirin:* used concomitantly may decrease *Motrin* blood levels.

Coumarin: bleeding has been reported in patients taking *Motrin* and coumarin.

Pregnancy and nursing mothers: *Motrin* should not be taken during pregnancy or by nursing mothers.

Adverse Reactions: The most frequent type of adverse reaction occurring with *Motrin* is gastrointestinal of which one or more occurred in 4% to 16% of the patients.

Incidence Greater than 1% (but less than 3%)—Probable Causal Relationship

Gastrointestinal: Nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence); **Central Nervous System:** Dizziness,* headache, nervousness; **Dermatologic:** Rash* (including maculopapular type), pruritus; **Special Senses:** Tinnitus; **Metabolic/Endocrine:** Decreased appetite; **Cardiovascular:** Edema, fluid retention (generally responds promptly to drug discontinuation; see PRECAUTIONS).

Incidence less than 1%—Probable Causal Relationship**

Gastrointestinal: Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, melena, gastritis, hepatitis, jaundice, abnormal liver function tests; **Central Nervous System:** Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma; **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia; **Special Senses:** Hearing loss, amblyopia (blurred and/or diminished vision, scotomata, and/or changes in color vision) (see PRECAUTIONS); **Hematologic:** Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit; **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations; **Allergic:** Syndrome of abdominal pain, fever, chills, nausea and vomiting; anaphylaxis; bronchospasm (see CONTRAINDICATIONS); **Renal:** Acute renal failure in patients with pre-existing significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria; **Miscellaneous:** Dry eyes and mouth, gingival ulcer, rhinitis.

Incidence less than 1%—Causal Relationship Unknown**

Gastrointestinal: Pancreatitis; **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri; **Dermatologic:** Toxic epidermal necrolysis, photoallergic skin reactions; **Special Senses:** Conjunctivitis, diplopia, optic neuritis; **Hematologic:** Bleeding episodes (e.g., epistaxis, menorrhagia); **Metabolic/Endocrine:** Gynecomastia, hypoglycemic reaction; **Cardiovascular:** Arrhythmias (sinus tachycardia, sinus bradycardia); **Allergic:** Serum sickness, lupus erythematosus syndrome, Henoch-Schonlein vasculitis; **Renal:** Renal papillary necrosis.

*Reactions occurring in 3% to 9% of patients treated with *Motrin*. (Those reactions occurring in less than 3% of the patients are unmarked.)

**Reactions are classified under "*Probable Causal Relationship (PCR)*" if there has been one positive rechallenge or if three or more cases occur which might be causally related. Reactions are classified under "*Causal Relationship Unknown*" if seven or more events have been reported but the criteria for PCR have not been met.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis. Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Do not exceed 2400 mg per day. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary.

Caution: Federal law prohibits dispensing without prescription. MED B-7-S

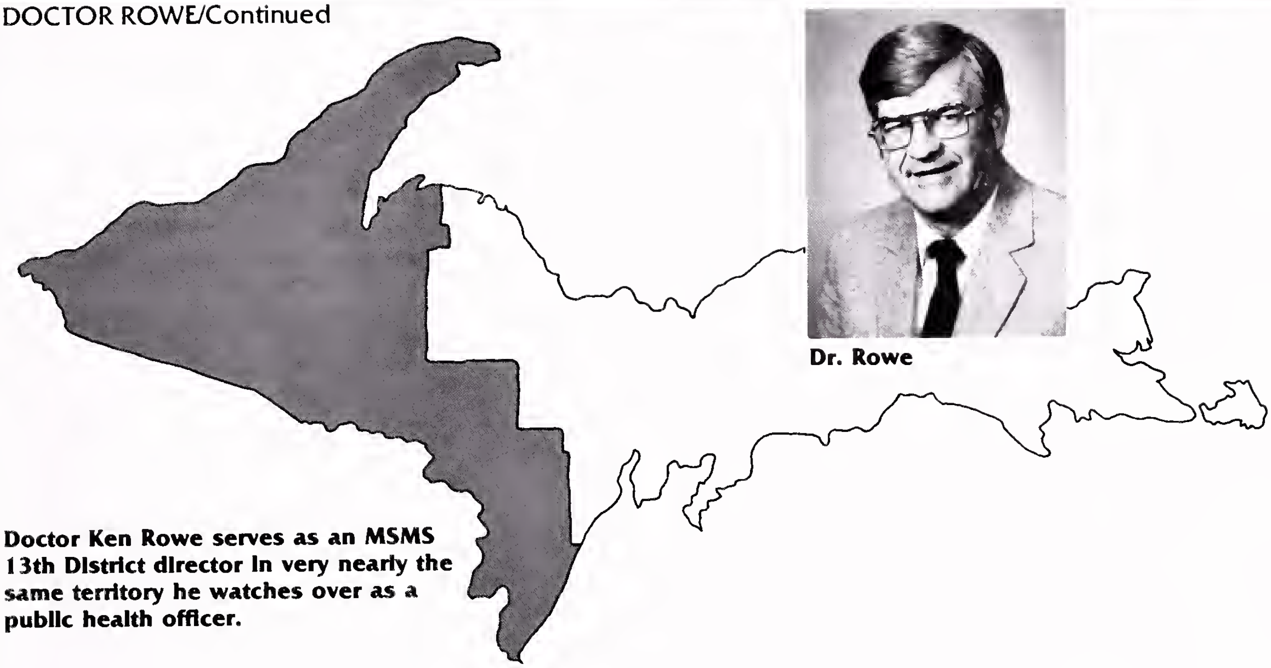
Motrin is a registered trademark of The Upjohn Manufacturing Company

Upjohn The Upjohn Company
Kalamazoo, Michigan 49001

J-4791 August, 1984

Ad Council
U.S. Department of Transportation
DRINKING & DRIVING CAN KILL A FRIENDSHIP.

Ad Council
A Public Service of This Publication.
©1984 The Advertising Council, Inc.



Dr. Rowe

Doctor Ken Rowe serves as an MSMS 13th District director in very nearly the same territory he watches over as a public health officer.

which is about one and a half miles wide and three and a half long, for sewage disposal. They also ascertained that a local mining company had deposited scrap in the lake for more than 50 years. Later, when a method was discovered to process this waste and secure more copper, the company dredged up the slag, processed it and redeposited what was left in Torch Lake. Chemicals involved in the reprocessing are considered the basic contaminant.

Doctor Rowe said it is a tough call, but he feels that since the towns have stopped using the lake for sewage purposes and since the rest of the trouble seems related to the bottom only, he feels the lake is safe for swimming. But no bottom feeding fish should be eaten, he has stated. He thinks the trouble will gradually subside.

Supports MSMS

Doctor Rowe is a solid supporter of the Michigan State Medical Society, and he enjoys his responsibility as a Board member from the thirteenth district. Since he is the "only bureaucrat" on the Board, he brings different views to meetings.

Doctor Rowe said he feels the organization serves the medical profession well and that he is delighted with the staff members he has met.

As he travels his area, which covers his MSMS district, he seeks reactions from MSMS members which will help him present their views at Board meetings. He also talks over MSMS programs with nonmembers and when appropriate, at hospital staff meetings. He meets with each component society in his area at least once each year. He tries in each case to define the impact of various bills under consideration in the Legislature and Congress and to evaluate the impact each would have should it become law. He identifies key lawmakers and encourages members to contact them to explain the significance of the proposed legislation. He takes special pains to distill major issues and their impact for Upper Peninsula doctors.

The most pressing concerns in the north, he identifies, are relationships with Blue Cross and Blue Shield for equal treatment with doctors in other areas, malpractice, and distribution of physicians.

He encourages all doctors to become members, although he thinks more than eighty percent of physicians in his district are already affiliated. He encourages more activity in MSMS.

One wall of Doctor Rowe's office is taken up with four viewing screens for x-rays. The opposite wall has a map of Isle Royale where he goes for relaxation a couple of times a year. It is clear that he values time fishing there.

One wall consists of windows. The fourth wall has pictures of his family. There is wife, Mary, a dental assistant since their children have left home. The couple has four sons and a daughter. One son is a senior at U-M medical school, another started medical training at Wayne State this fall.

Doctor Rowe grew up in Calumet; and he graduated from University of Michigan Medical School in 1955.

After two years in the Army Medical Corps, mostly as a captain in Italy, Doctor Rowe went into family practice in Calumet. In 1966, he moved into public health. In 1982 he was elected to his first term on the MSMS Board.

In recent years, he has served as team physician, working with athletes on Michigan Tech football, baseball, basketball and hockey teams. He or another doctor rotate in traveling with teams to each game.

Another activity he values is playing with a local band. Whenever possible, he plays his clarinet for public concerts.

CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, (517) 337-1351.

Date: October 17, Influencing Unfavorable Pregnancy Outcomes. Location: St. John Hospital. **Sponsor:** CME Committee of St. John Hospital. **For:** Interested physicians. **Cost:** $90.00. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road, Detroit 48236 (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: October 19, Strategies in Managing Chronic Pain. Location: Kalamazoo Center Hilton Inn. **Sponsor:** SMAHEC. **Contact:** Charles L. Zeller, MD, Southwestern Michigan Area Health Education Center, 1521 Gull Road, Kalamazoo, 49001. **Approved for:** 6 hours of Category I Credit.

Date: October 19, Hemodynamic Monitoring. Location: Gilmore Center for Health Education, Kalamazoo. **Sponsor:** SMAHEC. **Contact:** Charles L. Zeller, MD, Southwestern Michigan Area Health Education Center, 1521 Gull Road, Kalamazoo, 49001. **Approved for:** 6 hours of Category I.

Date: October 19, Basic Cardiac Life Support. Location: Towsley Center. **Sponsor:** Gilmore Center for Health Education. **Contact:** Office of Continuing Medical Education, University of Michigan Medical School, Towsley Center, Box 057, Ann Arbor 48109-0010, (313) 763-1400. **Approved for:** 6 hours of Category I Credit.

Date: October 19-20, Cardiovascular Update '84: and the beat goes on. Location: Northfield Hilton, Troy. **Sponsor:** American Heart Association of Michigan and American Association of Critical Care Nurse. **Contact:** Eleanor D. Peterson, RN, American Heart Association of Michigan, P. O. Box 160, Lathrup Village, 48075. **Approved for:** 7.9 hours of Category I Credit.

Date: October 19-20, Digital Subtraction Angiography: 1984. Location: Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit, 48202, (313) 876-3073. **Approved for:** 14 hours of Category I Credit.

Date: October 19-21, American Academy of Pediatrics-Michigan Chapter, Scientific Program. Location: Grand Traverse Resort Complex. **Sponsor:** Michigan Chapter, American Academy of Pediatrics. **For:** Pediatrics, Family Practice, DO's and Health Providers for Children. **Contact:** P. Miles Tiernan, 32245 Hearthstone, Farmington Hills, 48018. **Approved for:** 7 hours of Category I Credit.

Date: October 23, Infectious Disease Update. Location: Towsley Center. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010, (313) 763-1400. **Approved for:** 6 hours of Category I Credit.

Date: October 24, Alcholism: What it is and what to do about it. Location: Gilmore Center for Health Education, Kalamazoo. **Sponsor:** SMAHEC.**Contact:** Charles L. Zeller, MD, Southwestern Michigan Area Health Education Center, 1521 Gull Road, Kalamazoo 49001. **Approved for:** 7 hours of Category I Credit.

Date: October 24, "Neuropsychology in the Schools." Location: William Beaumont Hospital, Royal Oak. **Sponsor:** Neuroeducation Center, William Beaumont Hospital, Royal Oak. **Contact:** Neuroeducation Center, 3202 Coolidge Highway, Royal Oak, MI 48072. **Approved for:** 5 hours of Category I Credit.

Date: October 24-25, New Solutions to Clinical Problems in Allergy. Location: Towsley Center. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor 48109-0010, (313) 763-1400. **Approved for:** 12.5 hours of Category I Credit.

Date: October 25-27, 15th Annual International Symposium on Impant Surgery for the Hand and Upper Extremity. Location: Blodgett Memorial Medical Center and Amway Grand Plaza Hotel, Grand Rapids. **Sponsor:** American Society for Surgery of the Hand. **Contact:** Alfred B. Swanson, MD, 290 Blodgett Professional Building, 1900 Wealthy Street, SE, Grand Rapids 49506 (616) 774-7294. **Approved for:** 19 hours of Category I Credit.

Date: October 25-27, 1984, Magnetic Resonance and Ultrasound Physics Continuing Education Course. Location: Towsly Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, Ann Arbor 48109, (313) 763-1400. **Approved for:** 6 hours of Category I Credit.

Date: October 26-28, Manual Medicine Principles Applied to the Extremeties. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine. **For:** MDs and DOs. **Contact:** Sandy Kilbourn, A306 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 24 hours of Category I Credit.

Date: October 27, Annual Meeting of Michigan Neurological Association. Location: Botsford Inn, Farmington. **Contact:** Raymond B. Bauer, MD, 4201 St. Antoine 6G, Detroit 48201 (313) 494-4281. **Approved for:** 4 hours of Category I Credit.

Date: October 31, Practical Uses of Nonsteroidal Anti-infammatory drugs. Location: Gilmore Center for Health Education, Kalamazoo. **Sponsor:** SMAHEC. **Contact:** Charles L. Zeller, MD, Southwestern Michigan Area Health Education Center, 1521 Gull Road, Kalamazoo 49001. **Approved for:** 4 hours of Category I Credit.

Date: November 2-3, A Postgraduate Seminar on Screening for Common Cancers. Location: Sinai Hospital. **Sponsor:** Sinai Hospital. **Contact:** Trudy Ravi or Sheila Maniere, (313) 493-5279. **Approved for:** 12 hours of Category I Credit.

Date: November 3, Tenth Annual Symposium, "Child and Adult Analysis: Mutual Contributions." Sponsor: Michigan Psychoanalytic Society. **Contact:** Evangeline J. Spindler, MD, Chairman, 16310 West Twelve Mile Road, Suite 204, Southfield, 48076, (313)557-8633. **Approved for:** 3 hours of Category I Credit.

Date: November 7, Nerve Compression Syndrome and Nerve Injuries of the upper extremity. Location: Gilmore Center for Health Education, Kalamazoo. **Sponsor:** SMAHEC. **Contact:** Charles L. Zeller, MD, Southwestern Michigan Area Health Education Center, 1521 Gull Road, Kalamazoo. **Approved for:** 6 hours of Category I Credit.

Date: November 8-10, Laser Bronshoscopy, A Practical Course with Hands-on Experience. Location: Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit, 48202, (313) 876-3073. **Approved for:** 14 hours of Category I Credit.

Date: November 9-10, 32nd Annual Detroit Trauma Symposium. Location: Harper Hospital. **Sponsor:** Wayne State University, Department of Surgery and Michigan Committee on Trauma. **Contact:** Theresa Sokol, Wayne State University Department of Surgery, 6-C UHC, 4201 St. Antoine, Detroit, 48201, (313) 577-5009. **Approved for:** 9.5 hours of Category I Credit.

Date: November 14, Alcoholism. Location: St. John Hospital. **Sponsor:** CME Committee of St. John Hospital. **For:** Interested physicians. **Cost:** $90.00. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road, Detroit 48236 (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: November 18, Eighth Annual Pediatrics Seminar. Location: Kellogg Center for Continuing Education. **Sponsor:** Michigan State University College of Osteopathic Medicine's Department of Pediatrics. **Contact:** Sandy Kilbourn, A306 E. Fee, MSU-COM, East Lansing 48824, (517) 353-9714. **Approved for:** 6½ hours of Category I Credit.

Date: December 3-7, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine and North American Academy of Manipulative Medicine. **Contact:** Sandy Kilbourn, A306 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

Date: December 7, Care of the Burned Patient. Location: Towsley Center. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, University of Michigan Medical School, Towsley Center, Box 057, Ann Arbor 48109, (313)763-1400. **Approved for:** 7 hours of Category I Credit.

Date: December 8, Michigan Society of Pathologists December Seminar. Location: Rackham Auditorium, Ann Arbor. **Sponsor:** Michigan Society of Pathologists. **Contact:** Kenneth McClatchey, Department of Pathology, Unversity of Michigan Hospital, Ann Arbor. **Approved for:** 3 hours of Category I Credit.

Date: January 12, 1985, Primary Care Medicine: An Exciting Frontier Revisited. Location: Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit, 48202, (313) 876-3073. **Approved for:** 16 hours of Category I Credit.

Date: January 27-February 1, 1985, Schuss Mountain Conference in Emergencies in Medicine. Location: Schuss Mountain, Mancelona. **Sponsor:** Wayne State University, Department of Surgery, and Michigan Committee on Trauma. **Contact:** Theresa Sokol, Wayne State University Department of Surgery, 6-C UHC, 4201 St. Antoine, Detroit, 48201, (313) 577-5009. **Approved for:** 25 hours of Category I Credit.

Date: February 4-6, 1985, Hemodynamic Monitoring VII. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, Ann Arbor 48109 (313) 763-1400. **Approved for:** 14.5 hours of Category I Credit.

Date: February 27, 1985, Cardiology-Update. Location: St. John Hospital. **Sponsor:** CME Committee of St. John Hospital. **For:** Interested physicians. **Cost:** $90.00. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road, Detroit 48236 (313) 343-3877 **Approved** for: 8 hours of Category I Credit.

Date: April 10, 1985, Primary Care Medicine: An Exciting Frontier Revisited. Location: Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit, 48202, (313) 876-3073. **Approved for:** 16 hours of Category I Credit.

Date: April 25-25, 1985, 14th Annual Wayne State University Critical Care Symposium. Location: Northfield Hilton, Troy. **Sponsors:** Wayne State University, Department of Surgery, Michigan Committee on Trauma, and Michigan Society of Critical Care Medicine. **Contact:** Theresa Sokol, Wayne State University, Department of Surgery, 6-C UHC, 4201 St. Antoine, Detroit 48201 (313) 557-5009. **Approved for:** 12 hours of Category I Credit.

Date: May 6-8, 1985, Hemodynamic Monitoring VIII. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, University of Michigan, Ann Arbor 48109 (313) 763-1400. **Approved for:** 14.5 hours of Category I Credit.

Date: May 8, 1985, Pancreatitis. Location: St. John Hospital. **Sponsor:** CME Committee of St. John Hospital. **For:** Interested physicians. **Cost:** $90.00. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road, Detroit 48236 (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: May 9-10, 1985, A Team Approach to Aspiration Biopsy & Workshop on Aspiration Biopsy Cytology. Location: Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202, (313) 876-3073. **Approved for:** 12 hours of Category I Credit.

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

1st FOR PROFESSIONAL PROTECTION EXCLUSIVELY

YOUR FIRST STEP TO FIRST QUALITY PROTECTION
CONTACT FIELD REPRESENTATIVES

Eastern Office
JOHN K. GALLOWAY, THOMAS A. WEISMAN, WAYNE M. BACKUS,
CHARLES J. ROWE and MARK A. WHITMAN
6785 Telegraph Road, Suite 350, Birmingham, Michigan 48010
(313) 647-6640

Western Office
GEORGE J. HAWORTH
2600 Five Mile Road, NE, Suite 101
Grand Rapids, Michigan 49505
(616) 361-0863

Angina Protection with Benefits for a Lifetime

ONCE-DAILY CONTROL WITH HEART-SAVING BENEFITS

By reducing heart rate and cardiac contractility, INDERAL LA helps protect the heart from the potentially serious and debilitating consequences of ischemia. A highly effective antianginal agent for around-the-clock control of symptoms, INDERAL LA also provides cardiovascular protection for a sense of security in the years ahead.

PROTECTION AND EXPERIENCE NO CALCIUM BLOCKER CAN MATCH

Unlike calcium blockers, INDERAL LA—either alone or with a nitrate—is recommended for early treatment of angina in the majority of patients. Equally important, INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use.

START WITH 80 MG ONCE DAILY

Dosage may be increased to 160 mg once daily, as needed, to achieve optimal control. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY **INDERAL LA**

(PROPRANOLOL HCl) *LONG ACTING CAPSULES*

AL LA
AL LA
AL LA
80 mg
120 mg
160 mg

Ayerst®

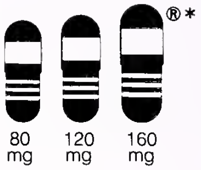
The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

JUST ONCE EACH DAY FOR SIMPLIFIED CORE THERAPY IN ANGINA

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient But there are also situations in which sympathetic stimulation is vital For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL

WARNINGS. CARDIAC FAILURE Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

> IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker In one case this resulted after an initial dose of 5 mg propranolol

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure Patients should be told that INDERAL may interfere with the glaucoma screening test Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy. Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block, hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved The usual maintenance dosage is 120 to 160 mg once daily In some instances a dosage of 640 mg may be required The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS)

MIGRAINE—*Dosage must be individualized* The initial oral dose is 80 mg INDERAL LA once daily The usual effective dose range is 160-240 mg once daily The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use

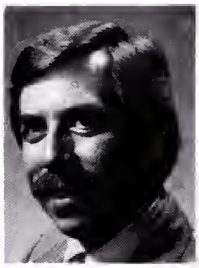
*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

8833/384

Ayerst.
AYERST LABORATORIES
New York, N.Y. 10017

By Joyce Crum

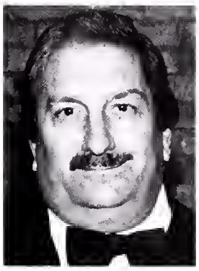
Atwater



Cotton

Oyen

Ryan



Smith

Jeffrey B. Halter, MD, Ann Arbor, has been named the first medical director of the Institute of Gerontology at The University of Michigan. He will conduct research and coordinate the institute's medical interests with other U-M developments in geriatric medicine. ... Named as the new president of the Michigan Public Health Officers Association is **John B. Atwater, MD,** Ann Arbor. ... **Russell F. Smith, MD,** Whitmore Lake, has been named outstanding alcoholism communicator of the year by the National Foundation for Alcoholism Communications. He received the Third Annual Marty Mann Award of the Foundation and *Alcoholism/the national magazine* at a ceremony in Indianapolis. Doctor Smith was honored for his more than 25 years of service in the field of alcoholism education. He also serves on the MSMS Steering Committee on the Program to Assist Impaired Physicians. ... Named as the Professional Man of the Year for his activities as chairman of the American Medical Association's Board of Trustees is **John J. Coury, Jr., MD,** Port Huron. He was honored at the 44th Annual Michigan Federation Convention of American-Syrian-Lebanese Clubs. ... **Stanley R. Smith, MD,** Petoskey, a Northern Michigan Hospital and Burns Clinic radiologist, has been appointed to a special ad hoc committee studying the use and placement of magnetic resonance units through the state of Michigan. The committee will develop guidelines for determining where magnetic resonance imaging units will be located. ... **James Dehlin, MD,** Gladstone, has been recognized by his peers as Michigan Family Practitioner of the Year. The annual award is based on a physician's medical knowledge and expertise in addition to community involvement. ... **Irwin S. Finkelstein, MD,** Bloomfield Hills, has been appointed medical director of the Tri-City Mental Health Center in Mesa, Arizona. He will be responsible for the directorship of clinical services at four branches in Mesa, Tempe and Chandler. ... **Ronald Krome, MD,** Detroit, is the new chief of the Department of Emergency Medicine at William Beaumont Hospital in Royal Oak. Doctor Krome also is a professor of surgery at Wayne State University's School of Medicine and chief of the Emergency Medicine section of the Department of Surgery. ... Newly appointed as chief of cardiology at Harper-Grace Hospitals as well as professor of medicine and chief of cardiology at Wayne State University, is **Joshua Wynne, MD,** Bloomfield Hills. ... **Robert Hartman, MD,** Saline, has been elected chief of staff at Saline Community Hospital for a two-year term. ... **Ralph A. Cram, MD,** Albion, recently published in the Michigan Academy of Family Practice Journal, an article on new guidelines for the immunization of Rh negative maternity patients. Doctor Cram is chairman of the MSMS Maternal and Perinatal Committee. ... **Inta J. Ertel, MD,** Ann Arbor, a University of Michigan professor of pediatrics, has been awarded a three-year grant by the National Institutes of Health. The $662,568 award will provide a training program for U-M residents in general pediatrics. ... **Jack Ryan, MD,** Detroit, president and chief executive officer of the Detroit-Macomb Hospital Corporation, has been elected chairman of the Michigan Hospital Association Board of Trustees for 1984-85. ... The new president of the Michigan Academy of Family Practice is **C. Edward Cotton, MD,** Marcellus. He was installed at the 28th Annual Michigan Academy of Family Practice House of Delegates meeting held recently. ... **Winifred Oyen, MD,** Midland, was presented the distinguished service award of the Michigan Public Health Officers Association at a summer conference meeting in Traverse City. ... **William Dobbins, III, MD,** Ann Arbor, professor of internal medicine at the University of Michigan Medical School, has received a grant worth more than $68,000 from the National Foundation for Ileitis and Colitis. The grant will be used to research the immunopathology of inflammatory bowel disease. ... New to the West Michigan Health Systems Agency Board of Directors is **M. Gary Robertson, MD,** Grand Haven. He is past president of the Ottawa County Medical Society and a delegate to the MSMS House of Delegates. ... Named chief of the radiology service at the Ann Arbor Veterans Administration Medical Center is **James H. Ellis, MD,** Ann Arbor.

Harold D. Crane, MD
Muskegon

Harold D. Crane, MD, Muskegon, died on August 7 at the age of 86. Doctor Crane served on the staff of St. Mary's Hospital for 53 years. He was a graduate of the University of Michigan Medical School and did his postgraduate studies at University of Michigan, Harvard University Medical School and Cook County Hospital. Doctor Crane served in the Reserve Officers Training Corps during World War I, enlisted in the United States Navy as a lieutenant commander during World War II and served in the Naval Reserves Medical Corps after his discharge.

Abilio S. Guimaraes, MD
Dearborn

Abilio S. Guimaraes, MD, Dearborn, died on June 28 at the age of 92. Doctor Guimaraes graduated from Emory University Medical School in Georgia before beginning his private practice in 1925 in Dearborn. After his retirement in 1976 Doctor Guimaraes and his wife, Dorothy made several trips to Portugal and Brazil.

Don M. LeDuc, MD
East Lansing

Don M. LeDuc, MD, East Lansing, died on August 11 at the age of 82. Doctor LeDuc graduated from the University of Michigan Medical School and served his residency in Detroit and Seattle. He taught anatomy, pathology and bacteriology at the University of Michigan for 12 years. Doctor LeDuc started practicing in Homer during the Depression and moved to Lansing in 1939. During World War II he served as a commander in the United States Medical Corps. He also served as chief of surgery at Edward W. Sparrow Hospital and was a member of the Senior Surgical Staff of that hospital, Ingham Medical and St. Lawrence Hospitals.

Donald W. McNaughton, MD
San Antonio, Texas

Former Genesee County doctor, Donald W. McNaughton, MD, San Antonio, Texas, died on August 10. He was 71. Doctor McNaughton graduated from the Vanderbilt University Medical School in 1939. He did his internship with the United States Public Health Service Hospital, Staten Island, New York. Before coming to Michigan in 1965 he practiced in Seattle, Washington and Aberdeen, South Dakota.

MEETINGS

MSMS, MSMS/A, AMA & medical assistants

Oct. 19-20 — Twelfth Annual Illinois Congress on Continuing Medical Education, Drake Oak Brook Hotel, Oak Brook, IL, contact: Illinois Council on Continuing Medical Education, 55 E. Monroe St., Suite 3510, Chicago, 60603, 312-236-6110.

Oct. 25 — Leadership Conference, Long's Convention Center, Lansing, contact: Sherry Wellman, MSMS headquarters.

Nov. 2-4 — Fall Leadership Seminar of the American Association of Medical Assistants, Hilton International Windsor, Ontario, Canada, contact: Caroline Rich, MSMS headquarters, East Lansing, 48823.

Nov. 13-15 — MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn, contact: Sherry Fent, MSMS headquarters, East Lansing, 48823.

Nov. 21 — MSMS Board of Directors meeting, MSMS headquarters, contact: William Madigan, MSMS headquarters.

Nov. 29-December 3 — Fourth Assembly Meeting of the AMA Hospital Medical Staff Section, Honolulu, Hawaii, contact: Bruce Ambrose, MSMS headquarters.

December 2-5 — Interim Meeting of AMA House of Delegates, Honolulu, Hawaii, contact: Bruce Ambrose, MSMS headquarters.

February 8-10, 1985 — Medical Assistants Midwinter Seminar, Midway Motor Lodge, Warren, contact: Caroline Rich, MSMS headquarters, East Lansing 48823.

April 26-28, 1985 — 1985 MSMS House of Delegates meeting, Michigan Inn, Southfield, contact: Richard Campau, MSMS headquarters.

June 16-20, 1985 — Annual AMA House of Delegates, Chicago, contact: Bruce Ambrose, MSMS headquarters.

OTHER MEETINGS

October 12 — 1984 MDA Oral Cancer Symposium, Delta College University Center, contact: Jamie DePolo, Michigan Dental Association, 230 N. Washington Sq., Suite 208, Lansing 48933.

October 19 — 35th Anniversary Celebration of American Academy of Pediatrics, Grand Traverse Resort Village, contact: P. Miles Tiernan, Executive Secretary - MDAAP, 32245 Hearthstone, Farmington Hills 48108.

October 26 — Excellence in School Health, Sugar Loaf Resort, Traverse City, contact: Richard Murdock, Michigan School Health Association, P. O. Box 11129, Lansing 48901.

November 4 — Annual Meeting of Michigan Neurological Association, Botsford Inn, Farmington, contact: Raymond B. Bauer, MD, 4201 St. Antoine 6G, Detroit 48201 (313) 494-4281.

November 7-9 — Occupant Protection and Alcohol Countermeasures, Boyne Mountain, contact: Michigan Life Savers, Office of Highway Safety Planning, 111 S. Capitol, Lower Level, Lansing 48913.

Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

In Hypertension*... When You Need to Conserve K^+

Remember the Unique Red and White Capsule: Your Assurance of SK&F Quality

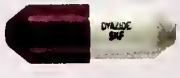
Potassium-Sparing

DYAZIDE®

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

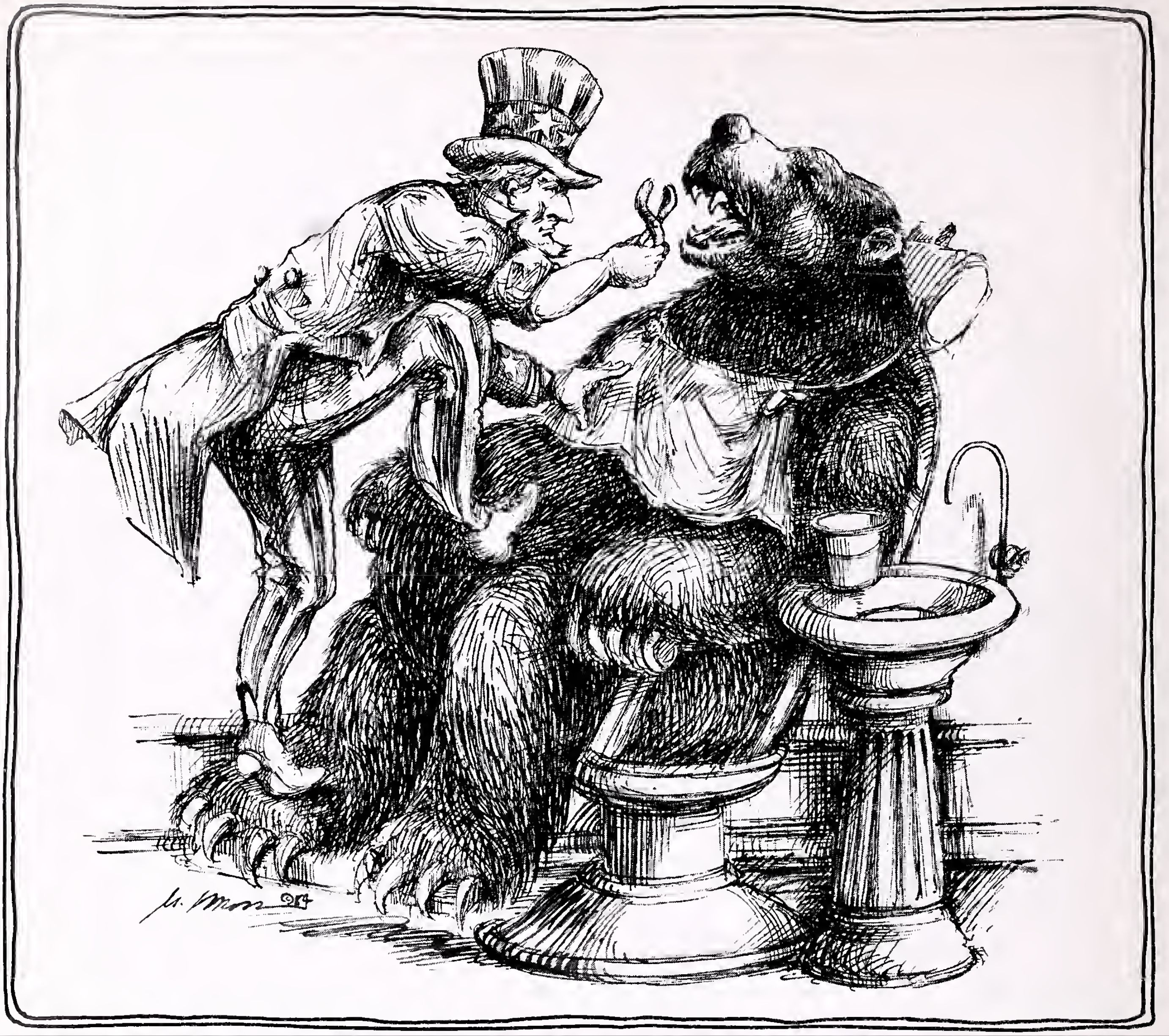
Over 17 Years of Confidence

The unique
red and white
Dyazide® capsule:
Your assurance of
SK&F quality.



a product of
SK&F CO.
Carolina, P.R. 00630

©SK&F Co., 1983



Taking The Bite Out Of The Bear.

Some Wall Street investors spend a lot of time looking over their shoulder. Even during bull markets, when things are surging ahead, they worry about the bear showing up to take a bite out of them.

But *you* can get the best of the bull and take the bite out of the bear, if you join the Payroll Savings Plan and buy U.S. Savings Bonds every payday.

Bonds have a variable interest rate, so when the bull is leading the Wall Street parade, you get to share in those higher returns. And where others may quake at the coming of the bear, you're protected by a guaranteed minimum.

Bonds let you relax and enjoy the bull markets, knowing that if the bear does make an appearance, for *you*, his growl will be worse than his bite.

UNITED STATES ★ SAVINGS BONDS ★

Take stock in America.

Ad Council A Public Service of This Publication & The Advertising Council

SELECTED TOPICS IN SURGERY

Eight distinguished authorities present their views on the management of major surgical problems in a one-day symposium.

Topics include:

- **The Elusive Parathyroid**/Edwin L. Kaplan, MD, professor of surgery - University of Chicago
- **Biliary Obstruction - Diagnosis and Treatment**/John W. Braasch, MD, assistant clinical professor in surgery - Harvard Medical School; Director, American Board of Surgery
- **Primary Therapy for Operable Breast Cancer**/Jerome A. Urban, MD, professor of clinical surgery - Cornell University Medical College; attending surgeon, Breast Service - Memorial-Sloan-Kettering Cancer Center
- **New Techniques in Colorectal Surgery**/Victor W. Fazio, MD, chairman, Department of Colorectal Surgery - The Cleveland Clinic Foundation
- **Management of Acute Pancreatitis**/Alexander J. Walt, MD, chairman, Department of Surgery - Wayne State University; chief of surgery - Harper Grace Hospital
- **Surgery for Reflux Esophagitis**/Edward R. Woodward, MD, professor of surgery - University of Florida
- **Management of Bacterial Peritonitis**/A. Martin Lerner, MD, clinical professor of medicine - Wayne State University
- **Inguinal Herniorrhaphy - The Shouldice Technique/** Nicholas Obney, MD, chief surgeon - Shouldice Hospital; Thornhill, Ontario

when Saturday, October 20, 1984

where South Macomb Hospital - Warren, Michigan

cost

physicians	$75
physicians-in-training	$25
allied health professionals	$25

To Register: Send check payable to Detroit-Macomb Hospital Corporation Annual Seminar Fund to:

Detroit-Macomb Hospital Corporation
Department of Medical Affairs
7815 E. Jefferson
Detroit, MI 48214
or call: (313) 821-6000, ext. 270

Six hours category 1 credit

The rate for each classified advertisement in *Michigan Medicine* is 20¢ per word, with a minimum charge of $10.00. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

POSITIONS OPEN

PEDIATRICIAN — NEEDED TO REPLACE RETIRING pediatrician in three man practice in Western Michigan. Must be Board certified or eligible. Reply to Box 67, Michigan Medicine, 120 W. Saginaw, East Lansing 48823.

PSYCHITRIST, PART-TIME, TO DO OUTPATIENT psychotherapy in private clinic in Adrian, Michigan, to do evaluations and psychotherapy; not to sign insurance forms or to prescribe medications. An excellent opportunity to work with experienced professionals (PhD, psychologists and MSWs) in pleasant and expanding private practice setting. Adrian, Michigan is located 35 miles southwest of Ann Arbor. Send resumé to: Brenda Meisels, ACSW, 3449 Brassow Rd., Saline, 48176, or call (313) 429-2463.

FAMILY PRACTICE AND URGENT/AMBULATORY CARE PHYSICIAN. Wanted to join excellent multispecialty staff. Rapidly growing financially sound HMO in midwestern university community. Competitive salaries and fringes. Reply to Box 69, Michigan Medicine, 120 W. Saginaw, East Lansing 48823.

ANESTHESIOLOGIST FULL OR PART TIME for Surgical Outpatient Facility in Oakland County. No evenings, no weekends. Call Medical Director (313) 681-2188. All replies will be kept confidential.

WANTED: FULL TIME EMERGENCY ROOM PHYSICIAN to work in a progressive, rural hospital Emergency Room in central Michigan. Flexible hours, good hourly wage with malpractice insurance included. Require ACLS. Contact Clare Community Hospital at (517) 386-9951, Ext 101, 102.

FAMILY PRACTICE-INDUSTRIAL MEDICINE a balanced practice awaits you in beautiful SE Wisconsin, Associate needed to share this rapidly growing practice. Contact Westmound Clinics, 683 Westmount, Waukesha, WI 53186, (414) 549-9100.

CARDIOLOGIST: OPPORTUNITY TO PRACTICE cardiology with well established practice conveniently located to a large teaching hospital. Duties include supervising and interpreting Treadmills, Holter monitors, 2D and M-Mode Echocardiography performed in office, patient examinations, hospital rounds and cardiac catheterizations. Abilities to do streptokinase and/or angioplasty desirable. Excellent beginning salary and fringe benefits. Located in Pennsylvania. Reply with CV to Box 66, Michigan Medicine, 120 W. Saginaw, East Lansing 48823. Immediate Opening.

TO SHARE: ST. CLAIR. WILL SHARE LARGE OFFICE with lab, x-ray, and operating room and excellent qualified staff with another physician. Private entrance and consultation rooms. Part or full time. Retirement situation? Terms open. (313) 329-2257 days or (313) 329-2020 and (313) 982-5165 evenings and weekends.

FREESTANDING PHYSICIANS MEDICAL GROUP: In Grand Rapids, Michigan, invites resumes from primary care physicians interested in full-time staffing of a freestanding urgent care facility. We prefer physicians with a background in family practice or emergency medicine who are interested in assuming roles of leadership in the staffing and operation of the facility. Duties will include functioning as an emergency physician, supervising and directing paramedical personnel. Interpretation of radiological, urological and hematological studies. The taking of medical histories and performance of physicial examinations. Repair of minor lacerations, immobilization of fractures and sprains. Consult and arrangement for follow-up as appropriate. Requirements for applicants must include a medical degree and licensure in the State of Michigan. Estimated base income will be equivalent to 36 hours per week at $35.00 per hour for an income of $54,000.00 per year. Malpractice insurance is fully paid. Please send your resume to: 21 Michigan St., NE, Suite 370, Grand Rapids, 49503.

FAMILY PRACTICE. GREATER FLINT HMO, a non profit subsidiary of Blue Cross-Blue Shield of Michigan, has several excellent opportunities for Board eligible Family physicians. The staff model HMO is two years old and growing rapidly. It offers the chance for physicians to practice true Family medicine in two beautiful facilities. Competitive salaries and a very attractive fringe benefit package are offered. Interested physicians should contact Doctor William Griz at (313) 733-9500.

PSYCHIATRIST: FULL TIME private or multispecialty group practice in Upper Peninsula of Michigan. Rural University Community. Significant mental health support. Send CV to D. Murphy, 821 Water Street, Hancock 49930.

GENERAL SURGEON — Board certified or board eligible. To join eight member family practice medical center. Have full-time radiologist. Major specialties consult on regular basis. Located at International Falls in northern Minnesota. Near Voyageurs National Park. Year around outdoor recreation abounds. Served by major airline. Population twenty thousand. Send curriculum vitae to Doctor James R. Schuft, Falls Medical Center, Shorewood Drive, International Falls, Minnesota 56649.

SUBURBAN ESTABLISHED INTERNAL MEDICINE PRACTICE-close to East Michigan industrial area and Major Medical Centers. Ideal for woman physician. Available in fall. Will assist in take over. Terms negotiable. Send resume to Box 63, Michigan Medicine, 120 W. Saginaw, East Lansing 48823.

MEDICAL DIRECTOR. OPPORTUNITY FOR PHYSICIAN with experience in medical group practice administration to join established HMO in Madison, Wisconsin. Group Health serves 29,000 patients with its staff of 20 physicians and total staff of 180. Excellent salary and benefit program. This represents a rewarding opportunity to develop or progress your career in medical administration. Contact: John Mueller, Group Health Cooperative, 1 South Park St, Madison, WI 53715; (608) 251-4156.

FAMILY PRACTICE. RAPIDLY EXPANDING STAFF MODEL HMO in Madison, Wisconsin, has opportunities for additional family practice physicians. Competitive salary with excellent benefits and attractive practice setting. GHC is an established, rapidly growing HMO serving 29,000 patients. Current staff totals 180 employees, including 20 physicians. Contact: John Mueller, Group Health Cooperative, 1 South Park St, Madison, WI 53715; (608) 251-4156.

OB/GYN. GROUP HEALTH COOPERATIVE has 1984 opening for Board certified/eligible obstetrician and gynecologist. GHC is an established, rapidly expanding HMO. Staff enjoy a stable salary plus excellent benefit program including 5-6 weeks of time off plus $3,000 CME funding. Madison is a city of 200,000 population; University of Wisconsin; and 4 lakes. Contact: John Mueller, Group Health Cooperative, 1 South Park St, Madison, WI 53715; (608) 251-4156.

FAMILY PRACTIONERS, GENERAL PRACTITIONERS or Emergency Medicine Physicians-with practice experience wanted for free-standing urgent care centers located in the Central Michigan area. Excellent access to recreational areas. Associate and Medical Director opening immediately. Other vacancies opening in August or September of 1984. Salary negotiable plus fringe benefits. Send C.V. to Contemporary Medical Management, Incorporated, 401 South Euclid Avenue, Bay City 48706 (517) 667-0494.

GENERAL SURGEON, OB/GYN AND INTERNAL MEDICINE PHYSICIAN to join seven doctor Family Practice Clinic in Cloquet, Minnesota, a community of 12,000 (30,000 service area) located 20 minutes from Duluth-Superior. Clinic facility is located one block from modern, well equipped 77 bed hospital. Cloquet enjoys a stable economy (forest products). Additionally, our community is noted for its excellent school system. First year salary guarantee, paid malpractice, health and disability insurance, vacation and study time. Contact John Turonie, Administrator, Raiter Clinic, Ltd., 417 Skyline Blvd., Cloquet, MN 55720. Telephone (218) 879-1271.

POSITIONS WITH THE STATE OF MICHIGAN—Currently taking applications for positions expected to be available in the future. Office locations now include Kalamazoo, Lansing, Southfield, and Traverse City. A board certified or board eligible psychiatrist needed for the Kalamazoo office, and internists desired for other offices. Beginning salary in low 60's with approximately 26% fringe benefits. An equal opportunity employer. All inquiries treated confidentially. For further details, please write: Chief Medical Consultant, Disability Determination Service, PO Box 30011 Lansing, 48909.

FAMILY PHYSICIAN: IMMEDIATE OPENING for a residency trained FP preferring small-town life style and interested in "whole person medicine from the Christian perspective" in a new office in the small college town of Hillsdale in southern Michigan. Write or call: Frederick L. Bean, MD, Hillsdale Family Practice, 111 South Howell, Hillsdale, 49242.

POSITIONS WANTED

OPHTHALMOLOGIST AVAILABLE for locum tenens. Board certified. Also interested in full time or part time position. Contact Box 39, Michigan Medicine, 120 W. Saginaw, East Lansing 48823.

MISCELLANEOUS

FP-OBS-GYN. PRACTICE FOR SALE. Well established practice grossing over $300,000, in nice recreational area in lower NE Michigan. Will introduce. Contact Box 68, Michigan Medicine, 120 W. Saginaw, East Lansing 48823.

MEDICAL PRACTICE FOR SALE. Located in Indiana. Specializing in Allergy and Clinical Ecology. Long established practice grossing over $390,000 with profit over $180,000. Confidential replies to Stewart D. Saliman, World Wide Real Estate, Inc., 1385 South Colorado Blvd., Suite 300, Denver, CO 80222 (303) 758-6877.

FOR SALE: A VERY PRODUCTIVE Medical Practice located in two offices — 22 miles apart — east of Flint, Michigan in mid-thumb area. Total Gross Corporate Income $197,000 with corporate expenses being 46%. Excellent hospital in one of the communities. Now working half day in each office 6 days per week. Desires to retire. Asking price of the Medical Practice will be discussed in person if interested, but a small down payment will be required and the balance can be financed over a period of 10 years at 10% interest. Respond to: Box 61, Michigan Medicine, 120 W. Saginaw, East Lansing 48823.

IDEAL LOCATION heavy traffic - Strip Shopping Center. $600 per month - Walled Lake, share space with Podiatrist. Call (313) 476-3850 or (313) 661-4070.

PHYSICIAN SELLING CUSTOM BUILT 9 year old lake front walkout ranch. Great room, family room and wet bar. Two fireplaces. Master bedroom opens to Florida type sun room facing lake. Two additional bedrooms and two baths up. Three bedrooms, one bath and sauna on finished lower level. Two stall attached garage and many more features. 100 foot lake frontage on large natural lake. Located 25 miles from Grand Rapids, Michigan 2 miles off expressway. Ideal for year around lake living or spectular summer home. Call (616) 774-0311 for more information.

HOWELL, MICHIGAN - OFFICE SPACE available in attractively designed professional building. Located within walking distance of hospital. For information call evenings (517) 546-8895.

HOLTER MONITOR SCAN SERVICE — Scanning for cartridge, cassette or reel-to-reel recorders by a company in the medical field for over twenty years. QUALITY REPORTS PRODUCED BY QUALIFIED TECHNICIANS AND CARDIOLOGISTS. Reports returned in 24 hours. Recorders and hook-up kits available. For further information call Advance Medical and Research Center 1-800-552-6753.

FOR SALE: NORTHWEST MICHIGAN CONDOMINIUMS, in Frankfort, "The Bluffs", panoramic view of Lake Michigan, gorgeous sunsets, situated in a quiet grove of stately hardwoods, all within city limits. Great fishing and skiing, excellant golf and swimming nearby. 3 BR, 2 bath, fireplace, private outdoor deck, over 1600 sq ft plus large storage room, laundry room and drive under garage. Approximately $102,000. Call Vaughan Realty in Frankfort (616) 352-4771.

ANN ARBOR GYNOCOLOGY PRACTICE available from retiring physician. Includes practice, office and furnishings. Very flexible terms. Call Bob Andrus, Andrus Davis Co, (313) 662-5911, evenings (313) 665-8113.

SANIBEL ISLAND, FLORIDA LIGHTHOUSE POINT condominium completely furnished for sale by owner. Never rented. Pristine condition. 3 bedroom magnificent bay view. Beach. $198,500.00. Assume 9% mortgage. (813) 472-3719 or (317) 251-0321.

WHY PAY PER SCAN? Lease brand new ACR Holter Recorder for under $70.00 per month! Medical Leasing Company, (313) 879-8860.

1985 CME CRUISE/CONFERENCES ON SELECTED MEDICAL TOPICS — Caribbean, Mexican, Hawaiian, Alaskan, Mediterranean, 7-14 days year-round. Approved for 20-24 CME Category 1 credits (AMA/PRA) & AAFP prescribed credit. Distinguished professors. **FLY ROUNDTRIP FREE ON CARIBBEAN, MEXICAN, & ALASKAN CRUISES.** Excellent group fares on finest ships. Registration limited. Prescheduled in compliance with present IRS requirements. Information: International Conferences, 189 Lodge Ave., Huntington Station, NY 11746. (516) 549-0869.

PHYSICIAN OPPORTUNITIES. Bernie Hoffmann Associates, Inc. is currently assisting a major metropolitan Detroit health care provider in the expansion of their suburban clinic network. The search for qualified physicians includes the following specialties: Obstetrics and Gynecology, Emergency Medicine, Family Practice, Internal Medicine, Orthopedic Surgery and Pediatrics. The typical satellite center provides an excellent practice setting for a four person physician group. There are over 30 opportunities for board eligible or board certified physicians with available starting dates of 10/1/84, 1/1/85, and 7/1/85. A compensation program emphasizing flexibility and incentive will be explored with invited candidates. Interested physicians should submit curriculum vitae in confidence to: Tim Ignash, Senior Associate, Bernie Hoffmann Associates, Inc., One Northland Plaza, 20755 Greenfield, Suite 601, Southfield 48075, (313) 557-9340.

MICHIGAN: PRACTICE OPPORTUNITIES NOW AVAILABLE. Immediate income from well established practice, malpractice insurance, fully equipped office, with a congenial staff. Excellent opportunity for ambitious physician. For more information contact: Emergency Consultants, Inc., One Windemere Place, Petoskey 49770; 1-800-253-7092 or in Michign 1-800-632-9650.

MICHIGAN: EMERGENCY CONSULTANTS, INC. currently staffs emergency departments throughout the state. Full-time and part-time positions available in rural and urban locations. Guaranteed hourly rate plus malpractice insurance. Contact Emergency Consultants, Inc., 2240 S. Airport Rd., Suite 115, Traverse City 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

FOR LEASE. PRIME, NEW PROFESSIONAL office space in the Union Lake - West Bloomfield area, Oakland County. New Professional office building in what will be the place to go for health care. A place with identity. Growing area, with solid base of older homes. One of the best locations in the Tri County area. Ideal area for specialists of any kind as they are needed. Custom designed suites from 800 to 6000 square feet. Great place to live. For information call (313) 363-0365 or 625-0660.

ESTABLISHED MEDICAL PRACTICES FOR SALE. All active. Practices are located in the following areas: Detroit, Roseville and Rochester. Please call Commonwealth Real Estate Group (313) 288-0022. Ask for Lydia Sikora.

FOR SALE: MEDICAL PRACTICE in North Oakland County. Sale Price: $34,000. Call Commonwealth Real Estate Group, Inc. (313) 288-0022.

INCOME PRODUCING INVESTMENT FOR SALE. Prestigous 18,000 sq. ft. office building, fully leased. Near 11 Mile and Lahser. $725,000. Terms: L/C 9% Interest. Call Commonwealth Real Estate Group (313) 288-0022.

WE HAVE QUALIFIED PURCHASERS looking to purchase Nursing Homes in Michigan. All inquiries confidential. Call Commonwealth Real Estate Group (313) 288-0022.

PRACTICES WANTED. We have qualified purchasers looking to assume established MD, DO and DDS practices in Metro area. All inquiries confidential. Call Commonwealth Real Estate Group (313) 288-0022.

FOR SALE. MARCO ISLAND CONDOMINIUM, high-rise, on the beach. Beautiful Gulf of Mexico view and island view. Two bedroom - two and one-half baths- approximately 2000 square feet. All amenities. For the discriminating buyer. Decorator furnished. Call area (313) 651-3871.

DOCTOR, YOU CAN'T BEAT THE QUALITY OR THE PRICE! Holter Monitor scanning service. Physician owned, trained and supervised. $35.00 for cassette reports: $45.00 for reel to reel reports; No contracts to sign. We can arrange for lease/purchase of holter equipment. Why are you paying more and getting less? DCG Interpretation (313) 879-8860.

ATTENTION DOCTORS: We have previously owned medical, laboratory, office and x-ray equipment in excellent condition. We buy, sell, broker and repair. Office appraisals available by certified surgical consultants. Call Doctor Medical Resale at (313) 569-4407 9 AM - 9 PM.

PHYSICIAN SIGNATURE LOANS TO $50,000. Up to 7 years to repay. No repayment penalties. Prompt, courteous service. Competitive fixed rate, with no points, fees or charges of any kind. Physicians Service Association, Atlanta, GA. Toll-free (800) 241-6905.

Thanks to our advertisers

AMRC	521
Ad Council	534,544
American Physicians Life	529
Ayerst Laboratories	500, 501, 502, 538, 539, 540
Bennethum Computer Systems, Inc.	528
Brown Pharmaceutical	497
Campbell Labs	516
Cogitum Medical Software	505
Detroit Macomb Hospital	545
GTE Telenet	490
Health Care News	512
Eli Lilly	513
MPMLC	510-511
MSMS ASM Meeting	IFC
Marion Labs	523-524
Medical Protective	537
Medprobe	547
Mini/Micro Computer	499
PICOM	527
Professional Practice Sales	532
Roche Labs	IBC-BC
Rollins Medical/Dental	507
Smith Kline & French	543
Stratton-Cheeseman	517
US Navy	519
Union Bank & Trust	531
Upjohn Company	533, 534
Woodside Capital Corp.	520
Worldwide Financial Seminars	518

MEDPROBE

"an information service in quality health care"

MEDPROBE
200 North Capitol Avenue, Lower Level
Lansing, MI 48933
517-321-0606

Of doctors and autos

Earlier I wrote about the exciting initiative of the Ford Motor Company in regard to health care benefits.

As you will remember, several weeks ago Ford officials approached MSMS, requesting that we set up an advisory panel to help them in developing and modifying their health care benefit package for salaried employees throughout the US.

I found this overture refreshing and a big step in the right direction. A series of meetings between members of the advisory panel and Jack K. Shelton, manager, and L. Susan Bischof, supervisor, Ford Employee Insurance Department, demonstrated several interesting facts.

Impressed

First of all, we MSMS representatives were impressed by the Ford officials' sincerity in seeking our advice and input. Secondly, we were struck by their detailed knowledge concerning employees who were using health benefits and the itemized and aggregate costs of such benefits on the one hand, and by their admitted ignorance of which benefits were appropriate and which were not, on the other hand.

Thirdly, we were duly impressed with the limited latitude the company has in restructuring health benefits for hourly employees. It appears that in this area the agenda is set by the UAW, period.

In all, this initiative promises a new and better approach to determining the depth and breadth of scope of benefits, as well as development of more effective utilization and quality assurance review for businesses.

Unfortunately, the Ford initiative, as of this writing, is somewhat unique in industry throughout Michigan and nationwide. As we all know, the prevailing approach to determining a health care benefit package is an adversarial one between management and labor, with the medical community totally excluded from the process.

Louis R. Zako, MD
MSMS President

Interestingly, the end result — dramatically escalating health care costs, bearing little or no relationship to outcomes, is blamed on the group left out of the process, namely the medical community.

Sad to say, there is no short term likelihood that hypocrisy will be replaced by reason and equity in health care matters. Recent events tend to confirm this observation. One example is General Motors' acquiescence to the UAW demand that first dollar coverage remain a sacred cow, with a variety of alternative approaches to cost containment through pressures on providers to cut costs by discounting. Implicit rationing is being the major thrust. Detroit Edison recently experienced a strike by its hourly employees, brought about largely by the company's efforts to reduce its health care benefits. Shortly before the onset of the strike, Edison announced an approximately 30 percent increase in salary and bonuses for its top official, who was paid nearly $400,000, I presume from the monies saved in the health area.

Shortly before the US Congess imposed a mandatory 15-month freeze on physicians' fees in the Medicare program (a freeze which the AMA Board of Trustees feels may be unconstitutional and which it is challenging in federal court), it rapidly agreed with the President that senior citizens, rich and poor, ought not be denied a cost-of-living increase in their social security benefits, even if the generous formula for determining these increases would determine that at the present low rate of inflation an increase was not warranted at this time.

It appears that the only way to save the Medicare program is to reduce payment to providers. It is a pathetic approach to public policy development, both because of its inequity and because of its inanity. Even if all physician payments for Medicare benefits were to be suspended for one year, the program will collapse within the next several years unless the White House and the Congress can muster the courage to modify the program in a substantive fashion.

Undoubtedly there are abuses and inefficiencies in health care in Michigan (i.e. total benefits paid by Blue Cross-Blue Shield for foot surgery), and throughout the nation. These abuses and inefficiencies no longer can be ignored.

It is time for those who vote themselves bonuses in the millions of dollars, while subsidized by import restrictions imposed grudgingly on the much less affluent taxpayers, to develop a greater social consciousness.

Bankrupting

Health care is a vital and necessarily expensive aspect of our social fabric. We must all work together to preserve the remarkably high quality of care provided the vast majority of our citizens, without imposing draconian rationing measures as are seen in England, without bankrupting the system.

COMPLETE LABORATORY DOCUMENTATION[1-5]... EXTENSIVE CLINICAL PROOF

FOR THE PREDICTABILITY
CONFIRMED BY EXPERIENCE

DALMANE® (IV)

flurazepam HCl/Roche

THE COMPLETE HYPNOTIC
PROVIDES ALL THESE BENEFITS:

- Rapid sleep onset[1-6]
- More total sleep time[1-6]
- Undiminished efficacy for at least 28 consecutive nights[2-4]
- Patients usually awake rested and refreshed[7-9]
- Avoids causing early awakenings or rebound insomnia after discontinuation of therapy[2,5,10-12]

Caution patients about driving, operating hazardous machinery or drinking alcohol during therapy. Limit dose to 15 mg in elderly or debilitated patients. Contraindicated during pregnancy.

DALMANE® (IV)
flurazepam HCl/Roche

References: **1.** Kales J *et al*: *Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A *et al*: *Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A *et al*: *Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A *et al*: *Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol 3*:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **9.** Amrein R *et al*: *Drugs Exp Clin Res 9*(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol 3*:303-326, May 1981. **11.** Greenblatt DJ *et al*: *Sleep 5*(Suppl 1):S18-S27, 1982. **12.** Kales A *et al*: *Pharmacology 26*:121-137, 1983.

DALMANE® (IV)
flurazepam HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

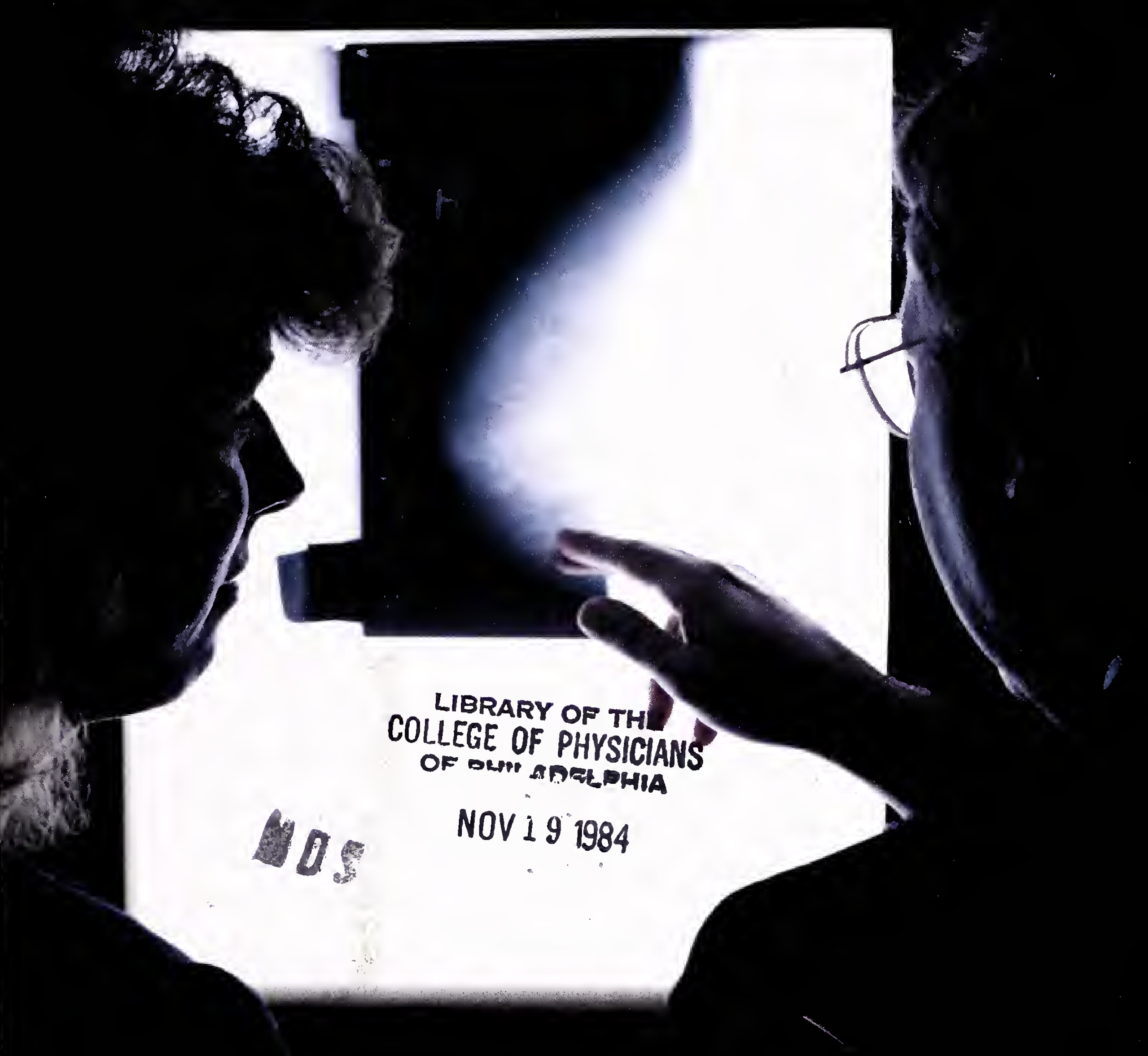
DOCUMENTED IN THE SLEEP LABORATORY[1-5]...
PROVEN IN THE PATIENT'S HOME
FOR A COMPLETE NIGHT'S SLEEP
DALMANE® Ⓒ IV
flurazepam HCl/Roche
STANDS APART
15-MG/30-MG CAPSULES
DALMANE® 30 ROCHE
DALMANE® 15 ROCHE

See preceding page for references and summary of product information.

Copyright © 1984 by Roche Products Inc. All rights reserved.

MICHIGAN MEDICINE

NOVEMBER 1984 JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Vol. 83, No. 51



LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA
NOV 19 1984

MDS

Informed consent and breast cancer

225 0000000000 123184
SERIALS DEPT - LIBRARY
COLLEGE OF PHYS OF PHILA
19 SOUTH 22ND STREET
PHILADELPHIA, PA 19103

Whom To Call At MSMS Headquarters

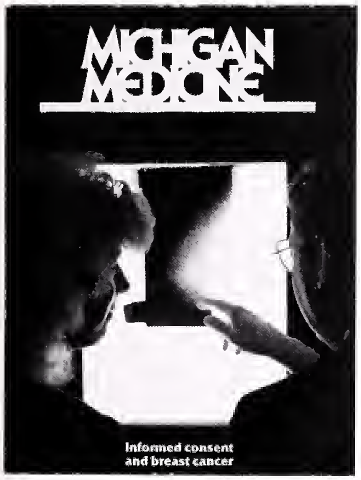
Executive Director: Bruce W. Ambrose
Managing Director: William E. Madigan

Address changes	Peg Berry
Advertising (in *Michigan Medicine*)	Sheri Greenhoe
AMA Delegation	Bruce Ambrose
Annual Scientific Meeting Program	Sherry Fent
Arbitration	Richard Campau
Auto Lease Plan	Wayne Burmeister
Blue Cross Blue Shield/Third Party Payors	John Richards
Board of Medicine	Kevin Kelly
Continuing Medical Education	
Accreditation	Katie Brewbaker
Category I Calendar (for *Michigan Medicine*)	Joyce Crum
MSMS-Sponsored Conferences	Sherry Fent
Dues Billing & Payments	Peg Berry
Financial Operations	Dick Campau
GTE/MINET	Ellen Vinocur Potash
HMOs/PPOs	John Richards
Hospital Medical Staff Relations	Thomas White
Impaired Physicians	Katie Brewbaker
Jail Health Project	Dick Campau
Judicial Commission	Vada Davis
Legislation	Kevin Kelly
Maternal Health Conference	Sherry Fent
Medicaid	Kevin Kelly
Medical Assistants	Caroline Rich
Medical Care Costs	John Richards
Medical Ethics	Vada Davis
Medicare	Debbie Zannoth
Medigram	Judy Marr
Member Services (Including insurance programs)	Wayne Burmeister
Membership Records	Peg Berry
Michigan Association for Medical Education	Vi Heins
Michigan Association of Emergency Medical Technicians	Vi Heins
Michigan Doctors Political Action Committee	Kevin Kelly
Michigan Chapter, American College of Surgeons	Vi Heins
Michigan Medicine (MSMS Journal)	Judy Marr, Sheri Greenhoe
Michigan Society of Anesthesiologists	Caroline Rich
Michigan Society of Internal Medicine	Caroline Rich
Michigan Society of General Surgeons	Caroline Rich
Michigan Society of Pathologists	Vi Heins
Michigan Society of Respiratory Therapists	Caroline Rich
MSMS Auxiliary	Vi Heins
MSMS Committee Meeting Schedule	Katie Brewbaker
MSMS House of Delegates Agenda and Schedule	Dick Campau
MSMS Meeting Facilities	Linda Munson
MSMS Travel Programs	Donna Farougi
Patient Information, MSMS PR Materials	Kirk McMurray
Physician Legislative Network	Daniel Farhat
Physician Service Group, Inc.	Vada Davis
Practice Management	John Anthony
Professional Liability Insurance	Richard Campau
Public Health	Kevin Kelly
Public Relations	Sherry Wellman
Specialty Societies	Sherry Wellman

MICHIGAN STATE MEDICAL SOCIETY, 120 W. SAGINAW ST., EAST LANSING, MI 48895 517/337-1351

November 1984, Vol. 83, No. 51

MICHIGAN MEDICINE



About the cover
The partnership of physician and patient in the treatment of breast cancer is illustrated by this month's cover. **Photo by Kim Kauffman.**

Free breast cancer brochures available

You may order a supply of the attached brochure, *Breast Cancer Treatments: A Helpful Guide For You* for use in your own office or clinic.

The pamphlet is designed for patients with just-diagnosed breast cancer and for those who simply want more information on this increasingly-common disease. It answers many of the "what if" questions your patients may ask.

Contact the MSMS Department of Communications and Professional Relations today for your supply of brochures. There is no charge.

In next month's issue of *Michigan Medicine:* How MSMS members benefit, and how MSMS is working to increase numbers of members.

Special Report

555 What does a physician tell a patient about her breast cancer? What does the patient want to know, and when? These are some of the tough ethical questions physicians face in this specialized area of informed consent. Not all patients in the past have been pleased with the handling of their cases, and they have said so to their legislators. Such reactions have led to the introduction of HB 5076, a bill which would require physicians treating patients with breast cancer to inform their patients about treatment alternatives. The bill, now under consideration by the House Public Health Committee, has been a catalyst to greater awareness on the part of patients and physicians, and has led to this month's special report. The MSMS Committee on Bioethics sponsors the report, which includes discussions of the bill's intent, the committee's functions, the importance of dialogue between physician and patient, the matter of informed consent and medical students' preparation for tackling ethical issues; Frederick W. Bryant, MD; Rep. Maxine Berman; Robert D. Allaben, MD; Marguerite R. Shearer, MD, and Marshall L. Shearer, MD; Howard A. Brody, MD, and Jeffrey Crumbaugh; W.E. Powers, MD and V. Ratanatharathorn, MD.

Features

IFC Who does what at MSMS headquarters

573 MSMS testifies at public hearing on omnibus medical malpractice bill; Katie Lane-Wilke

578 Bruce Ambrose, new MSMS executive director, sets goal of closer communication with members; Judith Marr

586 Key legislator profile: Sen. Paul Henry; Carole Eberly

597 MSMS offers members these benefits, with tear-off order form

602 Financial planning: How to advise your children on investing; Katharine S. Brown

615 MSMS Maternal Health Desk Reference Card 28: Use of Prophylactic Rho(D) Immune Globulin (RhIG)

621 "Ask the Doctors" show a hit in Marquette

Departments

551 Letters
606 Medical newsfronts
610 New members
617 Category I courses
618 Meetings
620 Members in the news
626 Deaths
630 Classified
631 Ad index
632 President's page; Louis R. Zako, MD

By Marion E. Alberts, MD

Changing practice environment opens new doors

The following viewpoint is an upbeat assessment of the ever-changing practice environment. It is reprinted with permission from the September, 1984 issue of *Iowa Medicine,* journal of the Iowa State Medical Society.

The practice of medicine has crossed a new threshold. Physicians starting practice today face a world of controls not imaginable by the young physician of 3 to 5 decades ago. The language is different, the mode of practice is different, the patient-physician relationship is changed, as are all the scientific aspects of diagnosis and treatment.

Many "older" physicians resign themselves to the new way of medical practice with the attitude, "I'm glad I can retire soon and be rid of the restraints of present day medical practice." We have witnessed the advent of third-party payors, utilization review, Medicare and Medicaid, and now DRGs, HMOs and PPOs. Are the opportunities the same?

The practice of medicine is highly personal. Our patients take us into their confidence and rightly expect us to rid them of their pains and infirmities. Traditionally, it has been a one-to-one relationship between the patient and physician. However, to perhaps a greater degree than we realize, that personal relationship appears to be waning. Many persons will accept being directed to a given physician or clinic by the provisions of their insurance policy. The closed panels of physicians claim the patients have a choice; that is true, but the choice is not unlimited.

Our mode of life often dictates to the patient his choice of physician — i.e., geographic location vs. the availability of a physician close by; lack of transportation to the physician of first choice, or the hours of availability. The practice arrangements of physicians are undergoing a change. More and more physicians are providing broadened office hours. Thirty or more years ago, the practitioner was in his office 7 days a week; housecalls were common place, and the relationship between physician and patient was a close one. Then housecalls became less frequent due to demands of the office practice as well as the belief that home medical service was less desirable. Saturdays and Sundays became sacrosanct regarding office hours. The consumer began to cry at the vendor. The patient considered the physician unavailable. The emergency room/outpatient facilities of hospitals became the off-hours medical care oasis. Now more physicians are providing evening and weekend hours at their offices for medical care. We have come nearly the full circle.

There is much meaning behind this evolution. It is obvious that the onset of illness, with its resultant pain and suffering, is not a 9-5, 5 days-a-week proposition. By banding together in groups or clinics, physicians can again make medical care more readily available. It is not "just what the doctor ordered;" it is "what the patient ordered."

What does all this have to do with the younger physicians and

Continued on next page

Doctor Alberts is scientific editor of *Iowa Medicine.*

Michigan State Medical Society
Bruce W. Ambrose, director

Committee on Publications
Harvey Andre, MD, Grand Rapids, chairman
Frederick W. Bryant, MD, Royal Oak
Vickers C. Hansen, MD, Manistee
Leland E. Holly II, MD, Muskegon
Richard L. Rapport, MD, Flint
Marguerite Shearer, MD, Dexter
Louis R. Zako, MD, Dearborn Heights
Editor
Judith Marr
Managing Editor
Sheri W. Greenhoe

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

MICHIGAN MEDICINE (ISSN 0026-2293) is the official journal of the Michigan State Medical Society, published under the direction of the Publications Committee. Published five times a month, 60 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $30.00; single copies, $1.50. Additional postage: Canada, $1 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to articles, news, exchanges and advertising should be addressed to Sheri W. Greenhoe and address changes to Peg Berry, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517-337-1351.

© 1984 Michigan State Medical Society

ALBERTS/Continued

opportunity? It means that the new generation of physicians can serve their patients as they want to be served. Though the patient is less dependent upon a close relationship with his own "personal" physician, he can obtain medical care more readily. Now is that all good, or quite bad? The days of the solo practitioner are said to be disappearing over the horizon; but, there still is a place for this mode of practice in some areas; limited, to be sure, as far as the future appears. Solo practitioners oftimes have arrangements with other physicians to "cover" at regular or irregular intervals. The patient receives personal attention for the most part, and the solo physician gets some free time.

Governmental regulations cause changes in our modes of practice; yet, the physician still has considerable freedom of action. Osler once said, "The young physician starts life with 20 drugs for each disease, and the old physician ends life with one drug for 20 diseases." Perhaps the new regulations will bring about some simplifications in the rendering of medical care. Certainly, we do not wish to simplify at the cost of good and adequate diagnosis and proper therapy; also, avoiding repetitious or redundant procedures can decrease the cost of medicine without denigrating the values medicine has gained over the years.

The new physician has great opportunities. There are opportunities to provide complete medical care, the first call of our profession. There are opportunities to rise above the complexities of our paper-ridden society (now becoming more computer-stored) and working towards methods of providing medical care advantageous to the patient (consumer), the fiscal agents responsible for paying the bills, as well as the physician (and now we are called vendors). Doors will open; some will slam shut before we enter; but the door of opportunity waits to be opened, and so it shall. ☐

Primary Sponsor efforts appreciated

On behalf of New Detroit, I want to express our thanks to you for your efforts thus far in encouraging physician participation in the Physician Primary Sponsor Plan. We hope you will continue to give this support.

The need for physician participation has become even more critical in recent months. The numerous enrollment methods now in effect are resulting in far greater numbers of recipients being asked to enroll in PPSP or one of the other cost containment programs in Wayne County.

We believe that recipients eligible for PPSP should be able to enroll with the physician of their choice, and retain an existing physician-patient relationship if so desired. In order for this to be possible, the desired physicians must be enrolled as sponsors. We therefore hope you will continue your efforts to encourage the participation of non-enrolled physicians.

Thank you.

Nathaniel Brooks
Senior Director
Health and Substance Abuse
New Detroit, Inc.

Malpractice insurance concerns

As 1985 is approaching, again it appears that the doctors in Michigan are facing a medical malpractice crisis. The insurance companies in Michigan such as PICOM, Michigan Physicians Mutual Liability Company, and Medical Protective Company of Fort Wayne, Indiana have started to cancel out physicians who they feel have an unacceptable frequency or severity of claims made against them. This again is leaving an increasing number of physicians in the state of Michigan to either "go bare" or try and seek malpractice coverage elsewhere.

If the practice of eliminating these physicians from the role of the insured especially in the medical specialties of Obstetrics and Gynecology, Orthopedics, and Neurosurgery continues, an increasing number of these specialists will have to either stop practice or move to states with a better malpractice climate.

To quote from an advertisement by PICOM in a recent issue of *Michigan Medicine* publication, "We defend you against non-meritorious claims. We won't settle a claim without your approval or to merely cut our defense cost." It appears that this is a true statement, but it also now appears that they are dropping what they term "high-risk" medical practitioners from their insured so that they can continue to increase their profits.

It is time that doctors in Michigan band together to obtain legislation where these medical malpractice companies will have to insure the high-risk physicians in a pool as done by the automobile insurance companies to insure high-risk drivers, so that all physicians in Michigan can obtain medical malpractice insurance and continue to practice.

I urge those in the Michigan State Medical Society to start handling this problem now before a further crisis arises and this practice is continued by medical malpractice companies.

Joseph Heitsch, MD
Clarkston

Angina Protection with Benefits for a Lifetime

ONCE-DAILY CONTROL WITH HEART-SAVING BENEFITS

By reducing heart rate and cardiac contractility, INDERAL LA helps protect the heart from the potentially serious and debilitating consequences of ischemia. A highly effective antianginal agent for around-the-clock control of symptoms, INDERAL LA also provides cardiovascular protection for a sense of security in the years ahead.

PROTECTION AND EXPERIENCE NO CALCIUM BLOCKER CAN MATCH

Unlike calcium blockers, INDERAL LA—either alone or with a nitrate—is recommended for early treatment of angina in the majority of patients. Equally important, INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use.

START WITH 80 MG ONCE DAILY

Dosage may be increased to 160 mg once daily, as needed, to achieve optimal control. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY **INDERAL® LA**
(PROPRANOLOL HCl) LONG ACTING CAPSULES

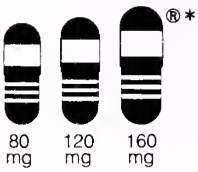
80 mg
120 mg
160 mg

Ayerst®

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

JUST ONCE EACH DAY FOR SIMPLIFIED CORE THERAPY IN ANGINA

ONCE-DAILY
INDERAL® LA
(PROPRANOLOL HCl) *LONG ACTING CAPSULES*



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL* LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient But there are also situations in which sympathetic stimulation is vital For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

> IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker In one case this resulted after an initial dose of 5 mg propranolol
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure, intensification of AV block, hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type

Central Nervous System: lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia, visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval

HYPERTENSION—*Dosage must be individualized* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS)

MIGRAINE—*Dosage must be individualized* The initial oral dose is 80 mg INDERAL LA once daily The usual effective dose range is 160-240 mg once daily The dosage may be increased gradually to achieve optimum migraine prophylaxis If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued It may be advisable to withdraw the drug gradually over a period of several weeks

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.
PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

8833/384

Ayerst. AYERST LABORATORIES
New York, N.Y. 10017

By Frederick W. Bryant, MD

MSMS Bioethics Committee studies some sensitive issues

Formed only eighteen months ago, the MSMS Committee on Bioethics is a relatively new addition to the long and varied list of standing committees. The members, in alphabetical order, are Frederick W. Bryant, MD, Royal Oak, Chairman; Howard Brody, MD, East Lansing; Anna M. H. Broecker, MD, Grand Rapids; Jeffrey S. Crumbaugh, Ann Arbor; James T. Harrison, MD, Lansing; John V. Hartline, MD, Kalamazoo; Sue A. Officer, East Lansing; Evan J. Reinders, MD, Muskegon; Marguerite Shearer, MD, Dexter; Kornelius Van Goor, MD, Grand Rapids, and Lester Weiss, MD, Detroit.

Created eighteen months ago as an investigatory task force, "Bioethics" has subsequently become a standing committee of the Michigan State Medical Society.

Early imperatives to delineate the field and become familiar with pertinent issues prompted study of a wide variety of texts and documents, such as the four volume *President's Commission Reports for the Study of Ethical Problems in Medicine, Biomedical and Behavioral Research, the Oakwood Hospital Guide for the Care of the Terminally Ill,* the Michigan Brain Death Statute — even current news clippings and media comments.

The accumulation of an appropriate library for use by MSMS members and others has become a major objective.

Interested and informed individuals have met with the Committee on specific issues: Representative Richard Fitzpatrick of the Michigan House of Representatives concerning surrogate parenting; Walter Wheeler, attorney for the Michigan Public Health Department, and representatives of the Michigan Society of Hospital Attorneys in relation to the Michigan Brain Death Statute.

On two occasions, Bioethics has written "white paper" suggestions resulting in position statements by the Board of Directors of the Michigan State Medical Society, one addressing protection of children who are the product of surrogate parenting, the other stating that Baby Doe and other handicapped individuals who cannot speak for themselves should be represented by family members close to them rather than by government officials.

In this issue of *Michigan Medicine* we take up the ethical question of breast cancer treatment.

Representative Maxine Berman believes that women with breast cancer have not always been fully informed by treatment options. As a means to correct this unfulfilled need she has introduced HB 5076 into the Michigan Legislature. It is the takeoff point for our discussion.

Representative Berman wants physicians to know the problem. In this issue of *Michigan Medicine* she states her views on breast cancer and informed consent. In turn, members of the medical community offer their observations. Understand the public concern voiced here: be aware of Representative Berman's strong convictions and earnest dedication, and acknowledge the right of patients to know the alternatives and to take part in decisions affecting the management of their ailments.

We welcome your comments.□

Doctor Bryant is chairman, MSMS Committee on Bioethics.

By Representative Maxine Berman

Informed consent: The case for legislation

Rep. Berman

As a legislator, I often am contacted by people with problems.

In most cases, the situation is an isolated one and can be remedied with a phone call or letter. However, there are times when I am contacted by many people with the same problem, at which point a closer look is required.

Such is the case with those who have undergone mastectomies. Both Representative Debbie Stabenow (D-Lansing) and I have received many letters from women in different parts of the state, and undoubtedly with different doctors, who contend that the various options available to them were not explained.

Intent of bill

In pursuing the matter, I checked other states with informed consent laws and also began gathering statistical information on mastectomies and the various methods of treatment. The bill I co-sponsor, HB 5076, was written to reflect that information.

Certain aspects of the bill and its intent ought to be understood.

First, HB 5076 is not intended to direct doctors toward one form of treatment over another. Indeed, the bill has no treatment preference. I fully understand that some treatments simply are not feasible, depending on the type and size of the malignancy. So do women who have faced the problem. But even when real options to mastectomy do not exist, knowing those other options and why they are unworkable would lead to far greater peace of mind for the patient.

Second, HB 5076 is not an indictment of the medical community. Many doctors do inform patients of options. And there are others who don't because they are genuinely and intellectually committed to a particular type of treatment. However, the latter, at the very least, should inform patients that other options exist and direct them to an appropriate source. This evidently is not happening.

Third, HB 5076 is not simply a response to vanity. Not one of the women who has contacted me has mentioned the issue of cosmetics. While the standards of the society we live in today may interject that as an underlying point, the real problem the bill addresses is undergoing surgery which may be unnecessary in light of new technology.

Fourth, HB 5076 is not just a "woman's issue," not only because of the incidence of breast cancer in men, but also because any patient facing any major illness obviously affects other people, particularly the immediate family.

Consumer issue

What informed consent really is is a consumer issue. We live in an era in which rapidly advancing communication technology has heightened public awareness—and public questioning—on many issues. The demand for a greater listing of ingredients on products, for example, or, more to the point, a better explication of the potential dangers of some of those products, reflects this heightened consciousness. And often, as it relates to the latter, the medical community deserves the credit for being in the forefront of this "awareness movement."

Surely, then, the patient as consumer has the right to know the various "ingredients" involved in a particular type of treatment, what risks are involved, and whether another "product," in this case another form of treatment, would be preferable.

So the era of informed consent is clearly here. Whether it is accomplished through legislation or some other process makes little difference. In fact, my preference would be for the professional community to instigate its own procedures. At this point, though, the mail in my office leads me to believe that simply is not happening.

As a legislator, I must respond to legitimate concerns of my constituents. I am, of course, open to suggestions as to how the matter can be resolved. But for the sake of the many who will be facing this illness in the coming weeks and months, we must act now. ☐

Representative Berman has served in the Michigan House of Representatives for two years. She serves the 64th District in Oakland County.

By Howard Brody, MD

The meaning of informed consent

While this special issue of *Michigan Medicine* deals specifically with the issue of informed consent in therapy for breast cancer, I think it is helpful to explore the concept of informed consent as it applies to medicine generally.

Useful reviews of informed consent focusing on legal issues are available in the medical literature. However, I have chosen to avoid this approach. The concept of informed consent has suffered from the view of physicians and nurses that this is strictly a legal fiction grafted artificially onto the care of the patient, instead of arising naturally from a concern that the patient be given optimal care.

So long as this view persists, we fear that informed consent never will be properly used. This will have several unfortunate consequences: patients will not get the best care nor the kind of attention from their physicians that they deserve, and the deterioration of the doctor-patient relationship and the resulting distrust will likely increase medical malpractice problems.

Informed consent is a more formal recognition of the process which ought to take place informally as part of the good doctor-patient relationship. It is based on a view of the doctor-patient relationship which is shared by most patients when they are questioned about their preferences.

In the literature, informed consent is rooted in the concept of patient autonomy, that is, respecting the patient as a free chooser, who should be given the opportunity to make informed decisions. The ethical concern is more for the opportunity to choose than for the choice itself.

If the patient freely foregoes the privilege, saying to the physician, "This is all very complicated, Doctor, what do you think I ought to do?", then the physician has not violated the patient's right to autonomy. Nor is the ethical value of autonomy undermined when a patient freely and voluntarily states, "I wish you wouldn't tell me a lot about the risks and side effects, because this information upsets and confuses me." The disclosure of information to the patient, like every other act in medicine, should be based on the patient's voluntary approval, and the right to refuse further information.

The legal standard of informed consent may not match the ethical ideal. Unfortunately, this is currently the state of affairs in Michigan.

Michigan courts adhere to the oldest current standard of informed consent, the community practice standard. The physician is obligated to disclose only what other physicians in the community are in the habit of disclosing.

Problems with informed consent

Why is the ideal of informed consent not more widely accomplished in practice? A recent study reveals several important obstacles to accomplishing informed consent.

One serious problem, of particular importance to the breast cancer issue, is the fact that physicians often avoid giving information about treatment options. These physicians state that they believe in theory that when there are legitimate treatment options, the patient should be informed and allowed to participate in the choice among them. But, in day-to-day cases, these physicians generally do not see that any options exist. They simply believe that one particular treatment is clearly the best, and that any other treatment would constitute substandard medical care.

Few physicians have been motivated to lie about alternatives; rather, they have been subject to a firm commitment, raised to a level of dogmatism, that the particular cancer treatment in which they trained is the only valid way of treating the disease. As long as physicians adhere to such dogmatic beliefs, they will feel no obligation to inform patients about alternative treatments. What is needed is not so much ethical clarification as scientific discussion of the legiti-

Continued on next page

Doctor Brody is coordinator of Medical Humanities and assistant professor of Family Practice at Michigan State University's College of Human Medicine.

mate alternatives to breast cancer treatment.

A number of patients have felt betrayed by the medical profession because they underwent major surgery without having been informed of possible alternative modes of treatment. These patients feel that they had a right to expect a certain kind of relationship with their physician and that they were denied that relationship.

This should be of grave interest to members of the medical profession. Physicians concerned about informed consent and the quality of the doctor-patient relationship should ask what steps can be taken to insure that incidents of this type do not recur.

This issue of *Michgan Medicine* is designed to address these issues. We provide a standardized patient information brochure listing alternatives in breast cancer treatment to help physicians address these legitimate patient concerns.

Another conclusion, however, is that the legislative mechanism is ill-suited to address the concerns that have been raised by these breast cancer patients.

Optimal Relationship

We have argued that it is erroneous to see informed consent as a legalistic issue and that informed consent ought instead to be viewed as an important part of the optimal doctor-patient relationship. However, attempts to legislate this relationship, which is based heavily on interpersonal trust and an individualized respect of a particular doctor for a particular patient and vice versa, seem particularly ill-advised and unlikely to succeed. When legalistic concerns become injected into the doctor-patient relationship without an understanding of how the issues evolved from a part of quality patient care, the likely result is not improved patient care; instead it is a proliferation of meaningless administrative rituals which do nothing to help either the patient or the physician.

Here are some practical guidelines for incorporating awareness of informed consent into the daily care of patients.

(1) Remember that informed consent is a process that occurs over time, and is not a single event. For any major medical decision, the process of informing and involving the patient in the decision may occur over several visits. Standard written forms may be handy as a reminder to the physician that unanswered questions persist, and may serve as a reminder to the patient that a decision of consequence has to be made and that the doctor is willing to discuss it further. Frank give-and-take in an atmosphere of trust and openness is far superior to any written consent form. For legal purposes it is important to state in the chart that this conversation occurred and to note its content.

(2) Information included in a discussion of a medical treatment decision generally consists of the different options for treatment, and the risks and benefits that can be expected to follow each option. Very serious consequences, such as paralysis, ought to be mentioned even though the probabilities that they will occur are very low; less serious risks of very low likelihood need not be mentioned unless the patient specifically asks to hear about them. The physician must, in deciding how much to disclose, be guided by the patient's desire for additional information. Whenever possible, risk statements should include local data based on actual experience.

(3) Patient education is a part of informed consent given in preparation for a medical treatment decision. Printed brochures can be useful, as long as they are incorporated into the discussion between doctor and patient and are not used as a subsitute for that discussion. It is always advisable to record specific patient education items given.

Some patients will resist full disclosure of information and will indicate a desire not to be involved in decision-making. When this desire is expressed by the patient after careful reflection, it should be honored. The patient's statement to this effect should be noted in the chart.

On the other hand, all too often this attitude of patients is based on the idea that physicians don't want patients to actively involve themselves in the decision, or that physicians are unwilling to spend the time necessary to inform the patients about medical treatment. When this happens, physicians may have to put forward extra effort to obtain patient participation.

As informed consent takes time and is an important part of medical care, physicians should schedule and bill accordingly. Third party payers are now willing to pay for second opinions in many cases; but some of the second opinions might be unnecessary had the first opinion been transmitted with adequate information and a thorough discussion with the patient.

(5) Physicans need to be ready to acknowledge when uncertainty exists, and use this as an opportunity to share decision-making perogative. Few patients expect medicine to have all the answers, and most respond quite positively to frank discussion.

(6) Early on in the contact with each patient, the physician ought to establish an atmosphere of interest in the patient's point of view and a willingness to answer questions. Later, this makes the task of informed consent easier.

If these practical guidelines are followed, informed consent will occur naturally as part of the doctor/patient relationship. The legal problem with informed consent will lessen to the manageable issue of good record keeping, except in rare cases where the patient's ability to consent is in question, or those extremely rare cases when the physician feels that disclosure of certain information would actually be detrimental to the patient's health. ☐

By Jeff Crumbaugh

Informed consent: a medical student's view

During a recent lecture at the University of Michigan on Amyotropic Lateral Sclerosis, commonly known as "Lou Gehrig's Disease," the professor presented a videotape in which a patient recited his own history, attempting to pick out events he felt were causative, or related to his illness.

Following the tape, the professor remarked that much of the patient's story (tendonitis, low back pain, two laminectomies) was unrelated to the true pathology of the disease, but that he, the teacher, had failed to point out this fact to the patient.

This promoted numerous questions from our class. Should the patient have been told his back pain and laminectomies had nothing to do with his present disease? Did he already know they were unrelated? Did he have a right to know? Was this important? Or was the physician right? After all, he knew the patient much better than we did.

For us as students it is important to consider and decipher the entire history, to separate and retain the relevant and disregard the irrelevant; that seems practical enough. But this situation brings up ethical considerations of patients' right to know about their illnesses and treatments.

When patients are told of their medical status and the proposed treatment is explained, we speak of them as being "informed." When patients agree to treatment, knowing the benefits and consequences, we speak of them as having given "consent." Together we have the principle of "informed consent."

But it's not always so simple. "Autonomy" and "paternalism" are terms that are thrown around, often at each other. The degree to which patients should be informed is debatable. Special situations apply to children and the mentally ill. What distills from all this is a complex problem with no easy solution.

Focusing on the problem

Recently, the issue of informed consent has been brought to the forefront in medical and legislative circles in Michigan. A number of women who were diagnosed as having breast cancer subsequently underwent mastectomy, only to learn later of less drastic alternative treatments. They felt that they had not been fully informed and expressed this view in discussions with legislators. As a result, House Bill 5076 was introduced by Representatives Stabenow, Berman and others.

In brief, the bill would require any physician in Michigan dealing with a patient diagnosed as having breast cancer to read a form to the patient describing all the consequences and benefits of all alternatives in treatment of breast cancer. This procedure, it is

Continued on next page

Mr. Crumbaugh is a medical student at the University of Michigan Medical School.

hoped, would insure that any woman with breast cancer would be fully informed of the entire gamut of treatment options and be in a position to make wise decisions.

Physicians must be sensitive to the feelings of these women and appreciate the significance of the legislative thrust. We also must recognize that most medical professionals firmly believe the responsiblity for communication with a patient should reside in an individual, the physician, and not in a law, or a committee or anything else. Moreover, many physicians are concerned by the tendency of our society to seek solutions to complex medical ethical dilemmas through legislation or through decisions made in the courtroom.

Does this leave us walking a tightrope between patient autonomy and paternalism? Perhaps.

Many people feel it is necessary to fully instruct patients of the risks and benefits of the specific therapeutic procedures proposed for them as well as alternative treatments and even no treatment at all.

Yet, for some patients there are significant negative psychological consequences of receiving such information. Consider the example of a man with lung cancer who agrees to undergo experimental chemotherapy.

Seemingly, he may appear to be fully informed concerning the risks and benefits of such treatment. But for him, it is shock enough to know he has cancer, let alone that the treatment will make him vomit and cause his hair to fall out. It would not be unusual for him to undergo denial, feeling grief and intense personal loss.

This disturbed man may not be giving valid informed consent at all. In this situation, it may be appropriate to give him time and to help him adjust to what is happening. Such a person needs warmth and understanding, not a sheet of paper which is read to him concerning the risks and benefits of various treatments. One cannot just set a tape recorder at the bedside and turn it on.

We might now ask, "Can legislation be pliable enough to deal with difficult and sensitive situations like this?"

There are practical limitations on the volume of information which can be transmitted to the patient. Surely the physician need not give a course in anatomy or pharmacology, but can explain the basic principles of the procedure and gear the information to the level of the patient.

However, what concerns me as a student is not what but how to tell a patient about disease and treatment. The way a physician interacts with a patient depends on the relationship between the two. Indeed, in many cases, the real problem may be a deteriorating physician-patient relationship. To quote an American physician, "The fact that the patient gave an informed consent usually will not prevent him from suing; a warm relationship with a competent, caring physician usually will."

Solving the problem

It is difficult to legislate competent, caring physicians. Technical competence already has been achieved to a great degree. But how do you teach caring and compassion? Some people feel you can't.

Clearly what is needed for physicians is a heightened self-awareness of the problem. We need additional elements in medical education. At Mount Sinai School of Medicine's Department of Medicine in New York, a program has been developed that teaches students not only about patient behavior, but also about physician behavior. Physician attitudes influence diagnostic techniques, dictate treatment decisions, and ultimately determine the doctor's style of communicating with the patient.

Teaching informed consent

All three major schools in Michigan have bioethics courses included in the pre-clinical years. The course at the University of Michigan is optional.

Of many Michigan students questioned about education of informed consent, however, many felt their pre-clinical courses were inadequate. One student felt there was no emphasis on the ethical issues involved.

Regardless of whether students feel their education concerning informed consent is adequate or not, there appears to be consensus that timing of that education should be primarily in the third and fourth years of medical school. Pre-clinical courses, while providing a background of the basic moral, ethical and legal issues, do not give the students hands-on practice in obtaining consent.

Robert Allaben, MD, associate professor of surgery at WSU and a fellow author of this report, feels that information relative to treatment options and complications is not difficut to teach. However, he feels the manner in which this information is presented to the patient **is** difficult to teach.

Other professors at the medical schools in Michigan agree. Indeed, they feel that this element of teaching requires much patience. Moreover, it requires the introduction to a wide variety of patients from well-educated persons to illiterate, suspicious individuals.

So, we see, the understanding of the patient is essential. This requires superior communication skills — skills that must be taught on the clinical wards in the real life time frame.

When we communicate well, we not only will be able to convey the information and consequences of treatment, but we also will be able to understand those things that trouble a person's heart. They are just as important.

(References are available from the author) ☐

By Marguerite R. Shearer, MD and
Marshall L. Shearer, MD

Addressing emotional aspects of mastectomy

Mastectomy is a devastating experience for most women; one in which the emotional suffering may far outweigh the physical.

As physicians we must discipline ourselves to be open to the patient's psychological stress, to expand our skills in dealing with her fears and depression in a supportive, gentle, and realistic way.

There are few physical conditions which threaten a patient on so many fronts simultaneously. We need to remain constantly cognizant of the fact that no woman escapes serious emotional trauma with a mastectomy.

Self-concept

The self-concept of the patient facing mastectomy is too often that of a mutilated, repulsive, desexed person who faces a lingering death. The woman with breast cancer suddenly and precipitously must confront her sexuality, her intimate relationships and her own death.

Quality of life is of vital importance; over a quarter of women who undergo mastectomy never fully recover psychologically and sexually despite an excellent medical result and prognosis. The physician's attitude and comfort in discussing sexual concerns and the ability to help couples talk together is often crucial in providing the information, support, reassurance and encouragement frequently needed for the couple to successfully resume sexual functioning.

Resumption of sexual relations can be of extreme importance to the patient, both for the physical, sensual pleasure and for the reassurance that she is able to do what "well", "normal" people do. Being sexual is a way of denying illness, and a healthy means of coping with the hopelessness and helplessness that is often felt by cancer patients; it is proof of vitality in addition to avoiding feelings of loneliness, desertion, or rejection.

Psychological ramifications of mastectomy are indeed awesome. Fear of cancer after mastectomy frequently decreases in intensity, but depression related to mutilation of the body will often persist for a considerable period; sometimes years. A positive body image implies normal breasts for most women; though age, state of life, and relationships modify the importance of body image concerns.

Breast development is usually the first sign for the girl, and the outside world, that she is becoming a woman. Many teenage girls spend time and emotional energy on issues pertaining to hiding or enhancing their breasts and how to dress to achieve this. Patients need time, and perhaps help, to change their perspective; placing the breast in the realistic context of a diseased organ rather than of a sex symbol.

Women with reconstructive surgery tend to do much better emotionally; even a partial reconstruction via silicone implants at the time of the initial surgery is often very beneficial. One patient expressed her pleasure with such an implant placed at the superior margin of the breast. This allowed her to wear some of her usual dresses.

Fragile relationships usually don't tolerate stress and anxiety well. Mastectomy patients frequently feel that the loss of the breast has been responsible for

Continued on next page

the breakup of a relationship. Fear that partners will find them repulsive is almost universal. The feeling of intense vulnerability and/or the fear that emotional or sexual openness and giving may expose them to pain or rejection causes many women to withdraw from their partners. Aspects of "mutilation" need to be separated from breast loss.

Male reaction

The effect of mastectomy on the patient's male partner also is considerable. For most men, the woman's breast was important in everyday caresses and in actual sexual relations. In one study, 73 percent of the spouses hardly ever touched the breast region postoperatively.

Wellisch et. al. examined 31 men with regard to their sexual reaction to mastectomy in their female partners, and to other factors. As a rule the men stated that sexuality and intimacy were seriously impaired and often negatively changed after mastectomy; for all of them, resumption of sexual relations was a critical point.

Husbands need to be talked with regarding their wives' depression, fear of loss of love, threatened feminity and need to be reassured. Fear of abandonment also is common. This patient will need her husband to hold her hand and tell her in words that he loves her, that she is the same woman inside, and that a change in contour is not going to matter. The chips are down at this time. It is difficult for many men who love their wives; they, too, will need support.

The patient's need for this reassurance is incredibly important and it should not be taken for granted that the husband will instinctively know to provide it. Women who seem to have coped will strongly believe that their husbands/partners were the most positive influence on their current functioning and recovery. The physician can help in these ways:

- Talk with the couple about her condition and the treatment options.
- Dispel misconceptions such as that the cancer is catching.
- Discuss prostheses and breast reconstruction. Once a procedure has been selected, tell both of them what to expect, what the wound will look like at stages they will see.
- Post-operatively, at an appropriate time in wound healing, invite the partner to touch the scar and the other breast. Help the patient make a "contract" with her partner that she will protect him from doing anything that is painful to her, and will tell him when she is fatigued, etc. Assure the partner that he may rely fully on this information and need not try to second-guess her.

A woman's adaptation to mastectomy is multifaceted and complex. Emotional health prior to surgery is a crucial factor in the psychological recovery of all cancer patients. Prior low self-esteem, depression and inability to deal with crisis are predictors of poor prognosis for the complete recovery from cancer.

Feelings of having been competently and responsibly treated by medical professionals help all patients maintain self-worth during the frightening and very dependent time of hospitalization. Some women react angrily to an authoritarian medical approach, which many physicians are trained in, i.e., they take responsibility for their patient's care and not expect to be questioned about their judgments.

Anxiety which breeds confrontation should be recognized by the doctor as the patient's need to be heard and respected. Women with recurrences who are passive and stoically submissive to medical care do not live long. One woman still poignantly in our memory has been followed regularly at a major teaching facility for dense fibrous dysplasia. She had mammograms which were disturbingly suspicious, but not clearly diagnostic of malignancy. Bilateral mastectomy had been recommended to her but she declined. Each visit she saw a different resident, and one day a young physician having just reviewed her chart, walked into the examining room and demanded to know why she hadn't had her breasts removed. She left after angrily asking him why he hadn't had his testicles removed, and changed physicians. After conferences with her previous physicians and arranging new consultants, she finally underwent bilateral mastectomy. Unfortunately, both breasts contained malignant tissue. We feel she would have responded more positively to earlier suggested surgery had the approach to her been more informative, and less authoritative.

Taking time

In conclusion, helping women with breast cancer is often difficult; the physician-patient relationship is very important. Some women feel so frightened, isolated, and lost that they are barely open to information and advice. At times just to give the patient time, to sit quietly with her is helpful.

Taking time with a person in a crisis is something significant. It is so simple, yet something which many physicians neglect, avoid, or underestimate. On occasion we physicians feel unjustly accused by our patients when they claim that they haven't been informed in detail. However, providing information effectively is a question of timing, of finding the right words, the right moment, and giving it in proper qualities.

Full and open discussion with warmth, compassion and tact as well as excellent medical and surgical skill, are important in our effort to be helpful in the care of the breast cancer patient. ☐

By Robert D. Allaben, MD

Alternative management of breast carcinoma

The Halstead standard radical mastectomy with or without additional radiation was the only choice in the management of breast carcinoma until approximately 20 years ago.

In recent years, we have used alternative treatment modalities. These treatment alternatives now are practiced on the European continent and are gaining acceptance in the United States.

The standard radical mastectomy generally has been replaced by the modified radical mastectomy. This surgical procedure leaves the pectoralis major muscle intact and may or may not include division or removal of the pectoralis minor muscle. Degrees of surgical conservatism range from this procedure to mere biopsy of the primary lesion and radiotherapy as the primary modality.

Treatment program

The selection of the treatment program for an individual patient depends upon many factors. These include - 1) state of disease, 2) histologic characteristics of the primary tumor, 3) psychosocial attitudes of the patient, 4) experience of the surgeon, 5) experience of the radiotherapist and availability of appropriate radiotherapy modalities.

Clinical staging of each patient should be carried out. T1 (tumors less than 2 cm. in diameter), T2 (tumors between 2 and 5 cm. in diameter) and occasional T3 (tumors greater than 5 cm. in diameter) who are NO (no clinically palpable involved axillary lymph nodes), N1a (moveable nodes not considered metastatic) and N1b (movable nodes considered metastatic) and who are also MO (no evidence of distant metastases) may be candidates for alternative treatment programs.

The primary lesion may be widely excised including at least 3 cm. of adjacent uninvolved breast tissue (quadrantectomy) or only the tumor excised (lumpectomy). If the latter alternative is chosen a booster dose of radiation should be applied to the tumor bed. This may be accomplished by external beam radiation or interstitial placement of 192 Ir(iridium).

The axilla may be ignored surgically, may have only the lower nodes removed for staging purposes or may be completely dissected for therapeutic and staging purposes. Axillary radiation is indicated in the first two instances and should not be applied if complete axillary dissection is carried out with possible exception of including the very highest portion of the axilla.

Most individuals use radiation to the entire remaining breast, although a few do not if a wide excision was carried out and there are no factors to suggest multicentricity.

Supraclavicular lymph node irradiation is generally advised in the presence of any axillary metastases. Internal mammary node irradiation is generally advised in the presence of medial or subareolar lesions or in the presence of axillary metastases.

If modifed radical mastectomy is selected the patient may be offered the option of immediate or later reconstruction using implanted material.

Adjuvant chemotherapy is advised in most instances where more than three axillary lymph nodes are involved and in many protocols if a single axillary lymph node is involved.

While treatment short of mastectomy, of course, leaves the majority of the breast intact, patients must be cautioned that short and long term results of ir-

Continued on page 564

The text of HB 5076

HB 5076: Informed Consent for Breast Cancer Patients

KEY SPONSORS: Reps. Stabenow, Berman and Evans

Introduced 10/27/83. House Committee on Public Health.

The bill will require physicians treating patients with breast cancer to inform patients about alternative treatments.

The bill was introduced due to growing concern nationwide that patients, women in particular, are not given adequate information about alternative treatments for breast cancer. In many cases, surgery is the only option offered to these patients. Proponents feel that providing more information about alternatives would allow patients to make better informed decisions about treatment.

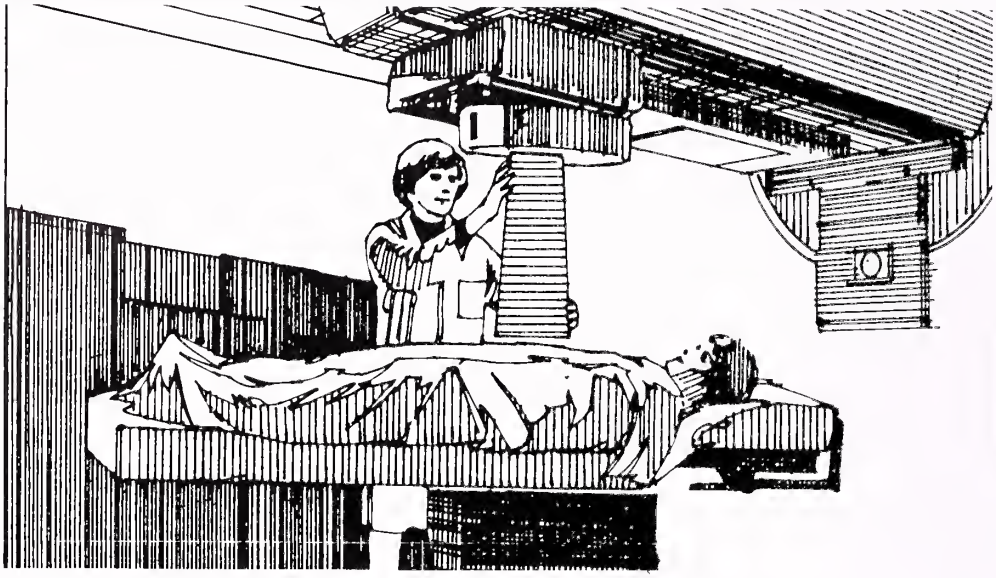
The bill:

1. Requires physicians treating patients with breast cancer to inform them orally, and in writing, in language the patient can understand, about all alternative methods of treatment that may be medically viable.
2. Requires a standard written summary of alternative methods:
   - — To be developed by the Department of Public Health (DPH) in cooperation with the Chronic Disease Advisory Committee
   - — To be in nontechnical terms
   - — To describe the advantages, disadvantages, risks, and procedures involved with each method
   - — To be available to physicians at the DPH's expense through the Board of Medicine and the Board of Osteopathic Medicine and Surgery. ☐

radiation cosmetically do affect the remaining breast tissue. Skin changes, fibrosis and shrinking occur to varying degrees in all patients.

Long-term studies are underway of these various means of managing patients with breast carcinoma. When matched carefully, they yield nearly identical long-term results. Local recurrences in patients who did not have a mastectomy may be treated by mastectomy at a later date. This operative procedure carried out in an irradiated field is subject to more complications.

In summary, the treatment of breast carcinoma has shown significant evolutionary changes within the last 20 years, and such changes will continue to take place. As appropriate, these alternative forms of management should be discussed with patients so that they may be involved in treatment decisions. □



On choosing radiation as cancer treatment

By W. E. Powers, MD and
V. Ratanatharathorn, MD

One of the many advantages of breast cancer treatment that conserves the breast is that patients are more willing to do breast self-examination and seek mammographic exam and other detection technique with the benefit of earlier diagnosis and a lower frequency of disseminated tumor. We estimate that of the 115,000 women who will be diagnosed in 1984 as having invasive breast cancer, approximately 7,000 patients are treated with conservation management while the technique could be employed in 85 percent of the women.

Eligibility

To be eligible for conservation management, the patients must be informed, cooperative and willing to participate in long-term follow-up. Patients with Paget's disease or with nipple-areolar involvement or with very large breast, or patients with small breasts with large tumor are not good candidates because they are less likely to have good cosmetic results.

Experience and rationale

Local radiation therapy following adequate surgical removal of the primary tumor has been evaluated by long-term clinical experience, matched-pair studies, and prospective radomized clinical trials and has resulted in excellent loco-regional control of breast cancer with preservation of the breast and thus represents the benefits of combined therapy. Only when the surgical procedures can be performed so as to spare the contour and configuration of the breast is it reasonable to perform this combined treatment.

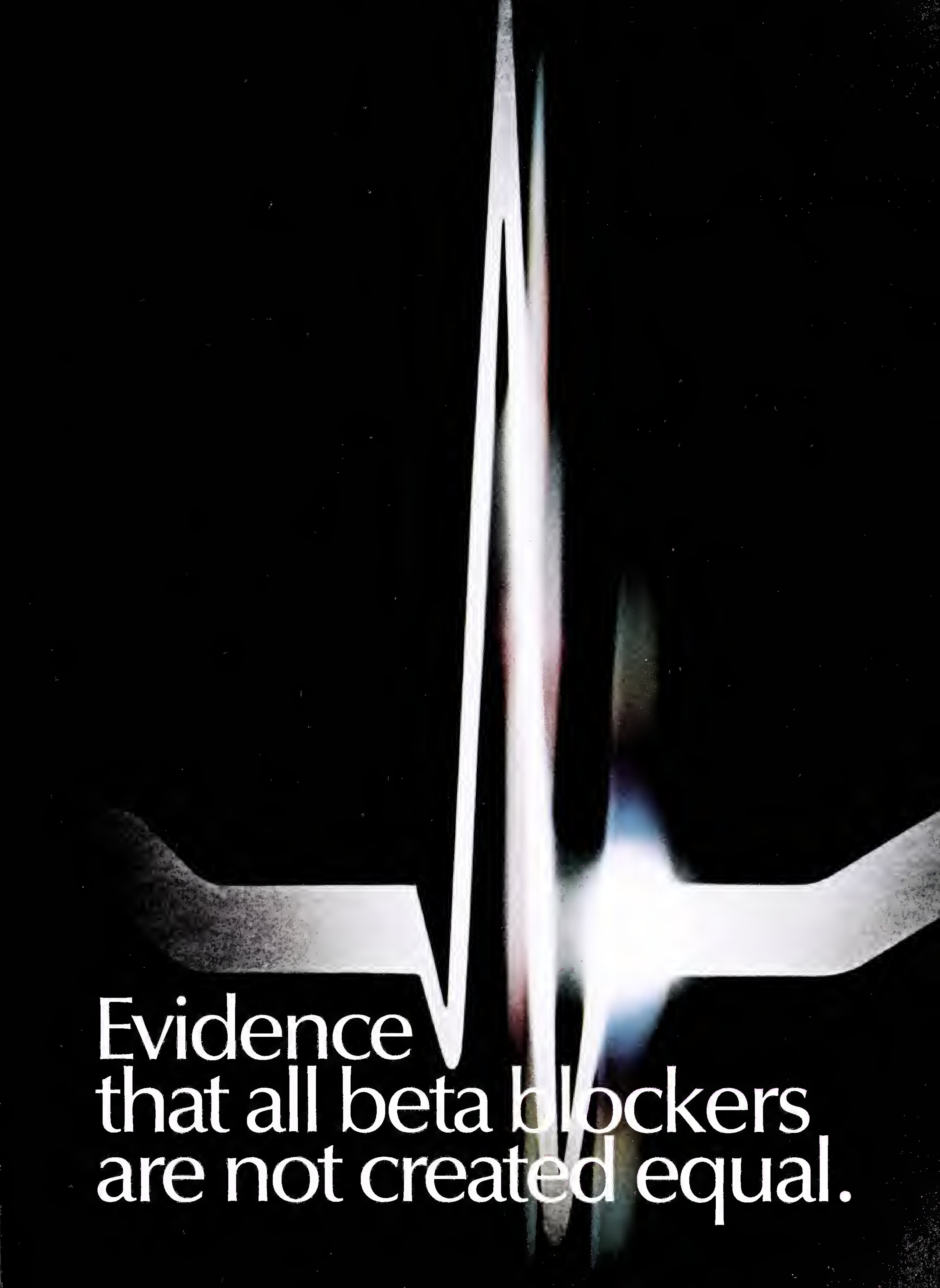
Local failure after radiation therapy varies from approximately 4-10 percent and depends upon the adequacy of the surgical margin and the radiation dose. Since local failure is usually at the primary tumor site, a boost dose is given by either electron beam (limited range in tissue) or temporary interstitial implant of radioactive substances (again a combined surgical and radiation therapy procedure).

Technique

The external radiation therapy requires fractionated, protracted precision radiation therapy with either a Co60 unit or a low energy linear accelerator using beam definition techniques to protect against inadvertent overlap of beams and tissue compensators to produce uniform doses (to give good cosmetic result and to minimize complication). The potential of later radiation carcinogenesis does not appear to be a problem unless patients have combined radiation therapy and chemotherapy for more advanced disease.

We employ interstitial radiation at the time of lumpectomy or axillary dissection to minimize error in implanting the tumor bed, to initiate treatment promptly as well as save the patient a second anesthetic and hospital admission. □

Doctor Powers and Doctor Ratanatharathorn are with the Radiation Oncology Center at Harper Hospital, Detroit.


Evidence
that all beta blockers
are not created equal.

New studies uncover the potassium effects of beta-2 blockade

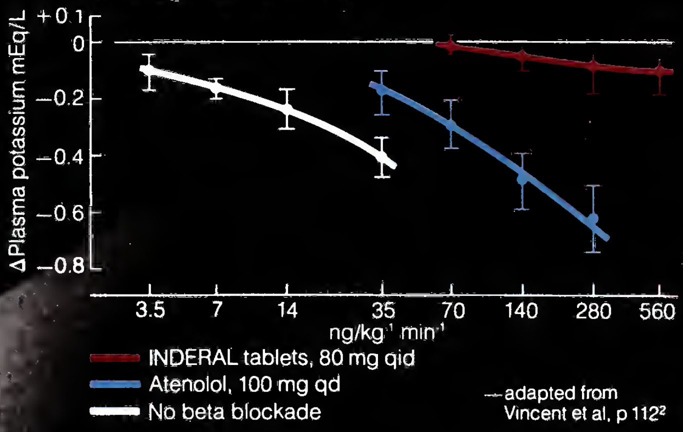
Clinical pharmacology data from the *New England Journal of Medicine:*

"...when normal young men are given infusions of epinephrine at levels such as those that circulate in patients with myocardial infarction, their serum potassium concentrations fall by about 0.8 mmol per liter. Hypokalemia is prevented by...beta-2 blockade."[1]

INDERAL (propranolol HCl) prevented beta-2 mediated hypokalemia

In a pharmacological study comparing INDERAL with atenolol, 10 hypertensive patients were infused with the nonselective beta agonist, isoproterenol, which also stimulates beta-2 mediated hypokalemia. At doses high enough to overcome beta-1 mediated heart rate reductions, the hypokalemia caused by isoproterenol was blunted by INDERAL, but not by atenolol.[2]

INDERAL compared with atenolol: change in plasma potassium after beta-agonist infusion[2]

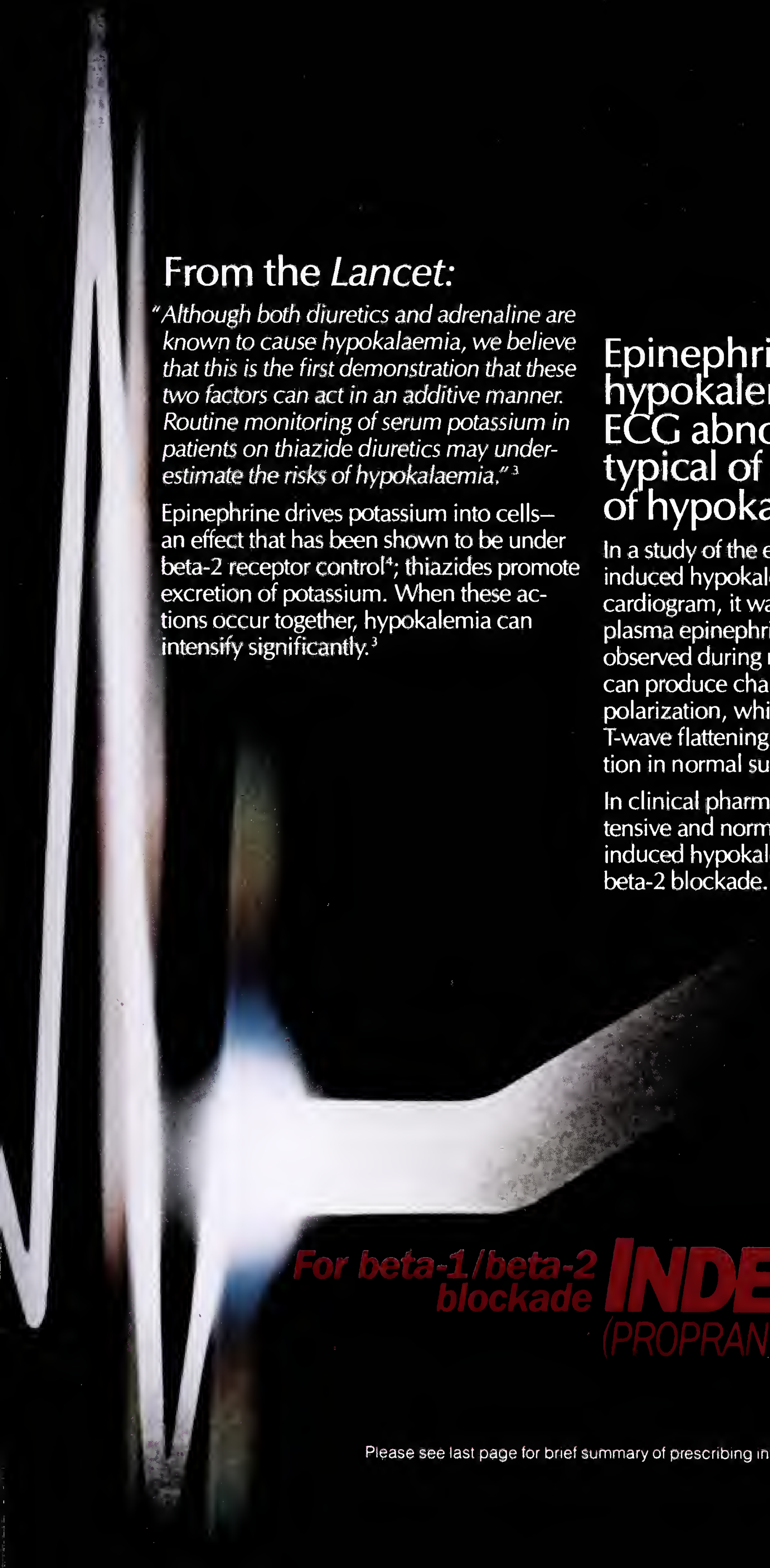


—adapted from Vincent et al, p 112[2]

For beta-1/beta-2 blockade INDERAL® (PROPRANOLOL HCl) TABLETS

Please see last page for brief summary of prescribing information.

Epinephrine-induced hypokalemia can intensify diuretic-induced hypokalemia



From the *Lancet:*

"Although both diuretics and adrenaline are known to cause hypokalaemia, we believe that this is the first demonstration that these two factors can act in an additive manner. Routine monitoring of serum potassium in patients on thiazide diuretics may underestimate the risks of hypokalaemia."[3]

Epinephrine drives potassium into cells—an effect that has been shown to be under beta-2 receptor control[4]; thiazides promote excretion of potassium. When these actions occur together, hypokalemia can intensify significantly.[3]

Epinephrine-induced hypokalemia can cause ECG abnormalities typical of other forms of hypokalemia

In a study of the effects of epinephrine-induced hypokalemia on the electrocardiogram, it was shown that levels of plasma epinephrine similar to those observed during myocardial infarction can produce changes in ventricular repolarization, which are reflected in T-wave flattening and QT prolongation in normal subjects.[5]

In clinical pharmacology studies of hypertensive and normal patients, epinephrine-induced hypokalemia was prevented by beta-2 blockade.[2,4]

For beta-1/beta-2 blockade INDERAL
(PROPRANOLOL HCl) TABLETS

Please see last page for brief summary of prescribing information.

Right from the start
in hypertension...

SPHYGMOMANOMETER
20
40
60
80
100
120
140
160
180
200
220
240
260
280
300

Once-daily INDERAL LA (propranolol HCl) for smooth blood pressure control without the potassium problems of diuretics

Patients with "uncomplicated" hypertension may develop ventricular arrhythmias in the presence of hypokalemia.[6] Once-daily INDERAL LA maintains smooth blood pressure reductions without a negative effect on serum potassium and provides patients with broad cardiovascular benefits—all in a convenient daily dose.

Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

And for lifetime benefits in foundation treatment of angina

Once-daily INDERAL LA provides 24-hour control of angina symptoms—plus the cardiovascular benefits of the world's leading beta blocker. And unlike calcium channel blockers, INDERAL LA, alone or with a nitrate, is recommended for first-line treatment of stable angina.

Simply start new patients on 80 mg INDERAL LA once daily. Dosage may be increased to 160 mg once daily to achieve maximal control.

Once-daily
INDERAL LA
(PROPRANOLOL HCl) LONG ACTING CAPSULES
In HYPERTENSION
and ANGINA

AL LA
AL LA
AL LA

80 mg 120 mg 160 mg

The appearance of these capsules is a registered trademark of Ayerst Laboratories.
Please see last page for brief summary of prescribing information.

INDERAL®
(PROPRANOLOL HCl) TABLETS

10 mg 20 mg 40 mg 60 mg 80 mg 90 mg

The appearance of these tablets is a registered trademark of Ayerst Laboratories.

Once daily
INDERAL® LA
(PROPRANOLOL HCl) LONG ACTING CAPSULES

80 mg
120 mg
160 mg
RAL LA
RAL LA
RAL LA

The appearance of these capsules is a registered trademark of Ayerst Laboratories.

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULARS.)*
INDERAL® (propranolol hydrochloride) **Tablets and Injectable**
INDERAL® LA (propranolol hydrochloride) **Long Acting Capsules**

INDICATIONS AND USAGE—INDERAL Tablets

Hypertension: INDERAL (propranolol hydrochloride) is indicated in the management of hypertension. It may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL is not indicated in the management of hypertensive emergencies

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL is indicated for the long-term management of patients with angina pectoris

Cardiac Arrhythmias:

1.) Supraventricular arrhythmias

a) Paroxysmal atrial tachycardias, particularly those arrhythmias induced by catecholamines or digitalis or associated with the Wolff-Parkinson-White syndrome (See W-P-W under WARNINGS.) b) Persistent sinus tachycardia which is noncompensatory and impairs the well-being of the patient. c) Tachycardias and arrhythmias due to thyrotoxicosis when causing distress or increased hazard and when immediate effect is necessary as adjunctive, short term (2-4 weeks) therapy. May be used with, but not in place of, specific therapy. (See Thyrotoxicosis under WARNINGS.) d) Persistent atrial extrasystoles which impair the well-being of the patient and do not respond to conventional measures. e) Atrial flutter and fibrillation when ventricular rate cannot be controlled by digitalis alone, or when digitalis is contraindicated.

2.) Ventricular tachycardias

Ventricular arrhythmias do not respond to propranolol as predictably as do the supraventricular arrhythmias a)Ventricular tachycardias. With the exception of those induced by catecholamines or digitalis, INDERAL is not the drug of first choice In critical situations when cardioversion technics or other drugs are not indicated or are not effective, INDERAL may be considered If, after consideration of the risks involved, INDERAL is used, it should be given intravenously in low dosage and very slowly (See DOSAGE AND ADMINISTRATION.) *Care in the administration of* INDERAL *with constant electrocardiographic monitoring is essential as the failing heart requires some sympathetic drive for maintenance of myocardial tone* b) Persistent premature ventricular extrasystoles which do not respond to conventional measures and impair the well-being of the patient

3.) Tachyarrhythmias of digitalis intoxication

If digitalis-induced tachyarrhythmias persist following discontinuance of digitalis and correction of electrolyte abnormalities, they are usually reversible with *oral* INDERAL. Severe bradycardia may occur (See OVERDOSAGE.) Intravenous propranolol hydrochloride is reserved for life-threatening arrhythmias Temporary maintenance with oral therapy may be indicated. (See DOSAGE AND ADMINISTRATION in the package circulars.)

4.) Resistant tachyarrhythmias due to excessive catecholamine action during anesthesia. Tachyarrhythmias due to excessive catecholamine action during anesthesia may sometimes arise because of release of endogenous catecholamines or administration of catecholamines. When usual measures fail in such arrhythmias, INDERAL may be given intravenously to abolish them. All general inhalation anesthetics produce some degree of myocardial depression. Therefore, when INDERAL (propranolol hydrochloride) is used to treat arrhythmias during anesthesia, it should be used with extreme caution and constant ECG and central venous pressure monitoring (See WARNINGS.)

Myocardial Infarction: INDERAL is indicated to reduce cardiovascular mortality in patients who have survived the acute phase of myocardial infarction and are clinically stable

Migraine: INDERAL is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope INDERAL also improves exercise performance The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta receptor stimulation. Clinical improvement may be temporary

Pheochromocytoma: After primary treatment with an alpha-adrenergic blocking agent has been instituted, INDERAL may be useful as *adjunctive* therapy if the control of tachycardia becomes necessary before or during surgery.

It is hazardous to use INDERAL unless alpha-adrenergic blocking drugs are already in use, since this would predispose to serious blood pressure elevation. Blocking only the peripheral dilator (beta) action of epinephrine leaves its constrictor (alpha) action unopposed

In the event of hemorrhage or shock, there is a disadvantage in having both beta and alpha blockade since the combination prevents the increase in heart rate and peripheral vasoconstriction needed to maintain blood pressure.

With inoperable or metastatic pheochromocytoma, INDERAL may be useful as an adjunct to the management of symptoms due to excessive beta receptor stimulation.

INDICATIONS AND USAGE—INDERAL LA Long Acting Capsules

Hypertension: INDERAL LA (propranolol hydrochloride) is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation Clinical improvement may be temporary

CONTRAINDICATIONS. INDERAL and INDERAL LA are contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL (propranolol hydrochloride) therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures

INDERAL, like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura

Auto-Immune. In extremely rare instances, systemic lupus erythematosus has been reported

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

REFERENCES.

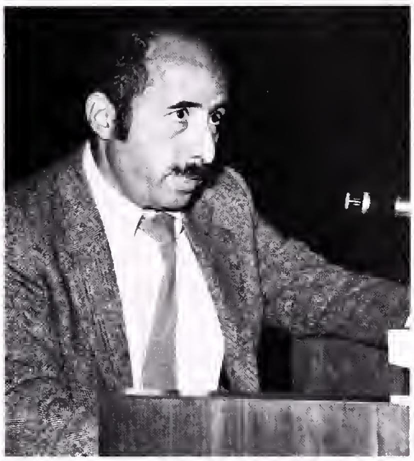
1. Epstein FH, Rosa RM: Adrenergic control of serum potassium. *N Engl J Med* 1983;309:1450-1451. **2.** Vincent HH, Boomsma F, Man in't Veld AJ, et al: Effects of selective and nonselective β-agonists on plasma potassium and norepinephrine. *J Cardiovasc Pharmacol* 1984,6:107-114. **3.** Struthers AD, Whitesmith R, Reid JL: Prior thiazide diuretic treatment increases adrenaline-induced hypokalaemia. *Lancet* 1983;1:1358-1361. **4.** Brown MJ, Brown DC, Murphy MB: Hypokalemia from beta$_2$-receptor stimulation by circulating epinephrine. *N Engl J Med* 1983;309:1414-1419. **5.** Struthers AD, Reid JL, Whitesmith R, et al: Effect of intravenous adrenaline on electrocardiogram, blood pressure, and serum potassium. *Br Heart J* 1983;49:90-93. **6.** Holland OB, Nixon JV, Kuhnert L: Diuretic-induced ventricular ectopic activity. *Am J Med* 1981;70:762-768.

9410/1184

Ayerst®
AYERST LABORATORIES
New York, N.Y. 10017

Copyright © 1984 AYERST LABORATORIES
Division of AMERICAN HOME PRODUCTS CORPORATION

By Katie Lane-Wilke



Abdul H. Alkhafaji, MD, Pontiac, addressed members of the Senate Judiciary Committee.

What doctors *and* lawyers are saying about the omnibus malpractice bill

The fate of a senate bill to regulate medical malpractice litigation remains uncertain after a second public hearing of the Senate Judiciary Committee October 5, in Pontiac.

Senator Patrick McCollough (D-Dearborn), the bill's sponsor, said that SB 224's chances of passage are less than even, but would be "good" if the bill were modified.

"The bill's arbitrary cap of $500,000 on non-economic damages I don't think will pass the legislature or survive the courts," he said, in an interview.

Currently in the state House of Representatives, the controversial bill has been vigorously opposed by attorneys, whose practices have involved malpractice cases in which they receive a percentage of awards to patients.

At the hearing, testimony for the bill came from twelve doctors including Louis R. Zako, MD, MSMS president, and Frederick V. Minkow, MD, former MSMS Task Force on Professional Liability chairman.

Opposing testimony came chiefly from Sheldon Miller, a prominent trial lawyer representing the State Bar of Michigan, and James A. Tuck, Michigan Trial Lawyers Association Task Force on Medical Malpractice. Representatives of Consumers' Council and National Women for Constitutional Government also testified against the bill.

The medical community reiterated its position that passage of the bill would help curb the increasing malpractice suits, skyrocketing insurance premiums, indirect costs of defensive medicine and other effects of the state's current malpractice climate.

Those opposing the bill portrayed the legislation as protecting the "perpetrator" rather than the "victim" of a malpractice suit and said it would not be effective in restricting the number of unwarranted malpractice suits filed.

Senator Basil W. Brown (D-Highland Park), Judiciary Subcommittee member, said the problem may be one of insurance and suggested inviting an insurance carrier that handles medical malpractice to a hearing to which Senator Richard D. Fessler (R-Union Lake, committee chairman, agreed.

The bill limits recoverable damages and other sources of increasing malpractice insurance rates. Included in the bill are five major provisions which would:

- permit consideration at trial of payment of a loss by a collateral source;
- specify the qualifications of expert witness;
- place a $500,000 cap on the amount recoverable for non-economic loss;
- provide for periodic payment of an award for future damages; and
- apportion the liability of multiple defendants according to the relative degrees of fault.

Here are capsules of the testimony of the principle proponents and opponents of the bill:

Doctor Zako: Total health-care costs are not going to be solved by SB 224. But if we're going to come to grips with total health-care costs, we have to deal with the problem in its many faceted

Continued on next page

Frederick V. Minkow, MD was one of twelve doctors to testify at the malpractice bill hearing.

Ms. Lane-Wilke is a Detroit-area freelance writer.

Louis R. Zako, MD, testified that the real impact of today's malpractice climate is felt in the doctor-patient relationship.

aspects and malpractice is a significant aspect.

The argument is that malpractice in its present configuration is needed to protect the public from bad doctors, but there is no relationship between who is sued and who wins and loses in court and the effective qualifications of that individual. In any one year, one out of every four physicians nationwide is being sued. I think it's some stretch of the imagination to claim that one-fourth of all physicians are incompetent.

MSMS really is concerned about the problem of bad doctors, and the tort system for medical liability is not the solution. It has not been the solution nationwide and it's not going to be the solution in Michigan.

The real impact of the present malpractice climate, which is not measurable and which is difficult to articulate, is the adversarial relationship between patient and doctor. Malpractice suits change doctors' attitudes toward patients. We can't foster a climate of adversarial relationships between doctors and patients when a patient is sick and scared and a doctor is trying to do his or her best to try to help that patient with recovery.

Let me summarize by saying SB 224 is extremely modest, reasonable and equitable and I recommend its passage.

Doctor Minkow: I'm here today to speak not as chairman of any particular committee, but as a private practicing physician. I'm aware through my hospital activities of the feelings of many physicians who come to me and pour out their guts trying to explain what it is that's changing the way they're practicing medicine.

The average physician who works in the emergency room and comes to see a patient immediately has to think what is the standard of care that has been determined in some previous legal decision or some previous court of law. This kind of thinking really has no place in medicine, yet it is prevalent. The obstetrician/gynecologist is being attacked right now. Many physicians, and it's becoming an increasingly large percentage, will no longer practice or deliver babies. Gynecologists now are paying malpractice premiums that are forcing them to *stop* delivering babies.

In summary, I certainly hope that SB 224 can pass some things that may very well save a considerable amount of money and alleviate some of the fears that are arising.

Sheldon Miller: Before addressing the bill, I think I should say a couple of things. It (the bill) does not protect malpractice victims, and it does not address unwarranted allegations or so-called "frivolous" lawsuits. There already are rules that provide that when a lawyer files a claim of unwarranted allegations that that lawyer and his client can be responsible for all the costs incurred in defending against unwarranted allegations. So the protection is there.

Four parts of the bill protect doctors responsible for perpetrating malpractice. And the fifth deals with the qualifications of those expert (witnesses). While it can also protect doctors who are guilty of malpractice, it protects *any* doctor against whom a claim is made. And it sets very high standards. So high are those standards, in fact, that it takes better credentials to testify in a court of law than it takes to do open heart surgery.

This legislation cuts down the victim's loss to protect the defendant. The solution is for doctors to carry adequate insurance. To summarize, let me say the complaints we've heard here today are not addressed by this legislation.

James Tuck: We have to analyze where our problems are in Michigan. I hear frustration from the medical community and the reason that we have this frustration is because the insurance companies that are servicing the physicians in this state are making a lot of money and are building tremendously large financial institutions. These physicians are striking out at their patients and their consumers rather than trying to address the problems they have.

Defensive medicine is a little bit of a state of mind. We all get sued in this business whether we're doctors or lawyers. If we are intimidated by the fear that we're going to be sued, we're not being fair to ourselves or to the system, and I don't think the legislature ought to respond to these fears.

One of the issues raised this morning that I think cuts to the heart of the opposition the MTLA has raised regarding this bill is the issue of mandatory insurance. We can solve the joint and several liability problem and we can improve the quality of medicine in this state by requiring mandatory insurance. One of the important aspects of this bill would cut down the ability of injured people to get medical expert testimony into the courtroom. That rule is unfair. It's an intentional and a very professional way of intimidating consumers. ☐

BROWN THE BROWN PHARMACEUTICAL CO., INC.

2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

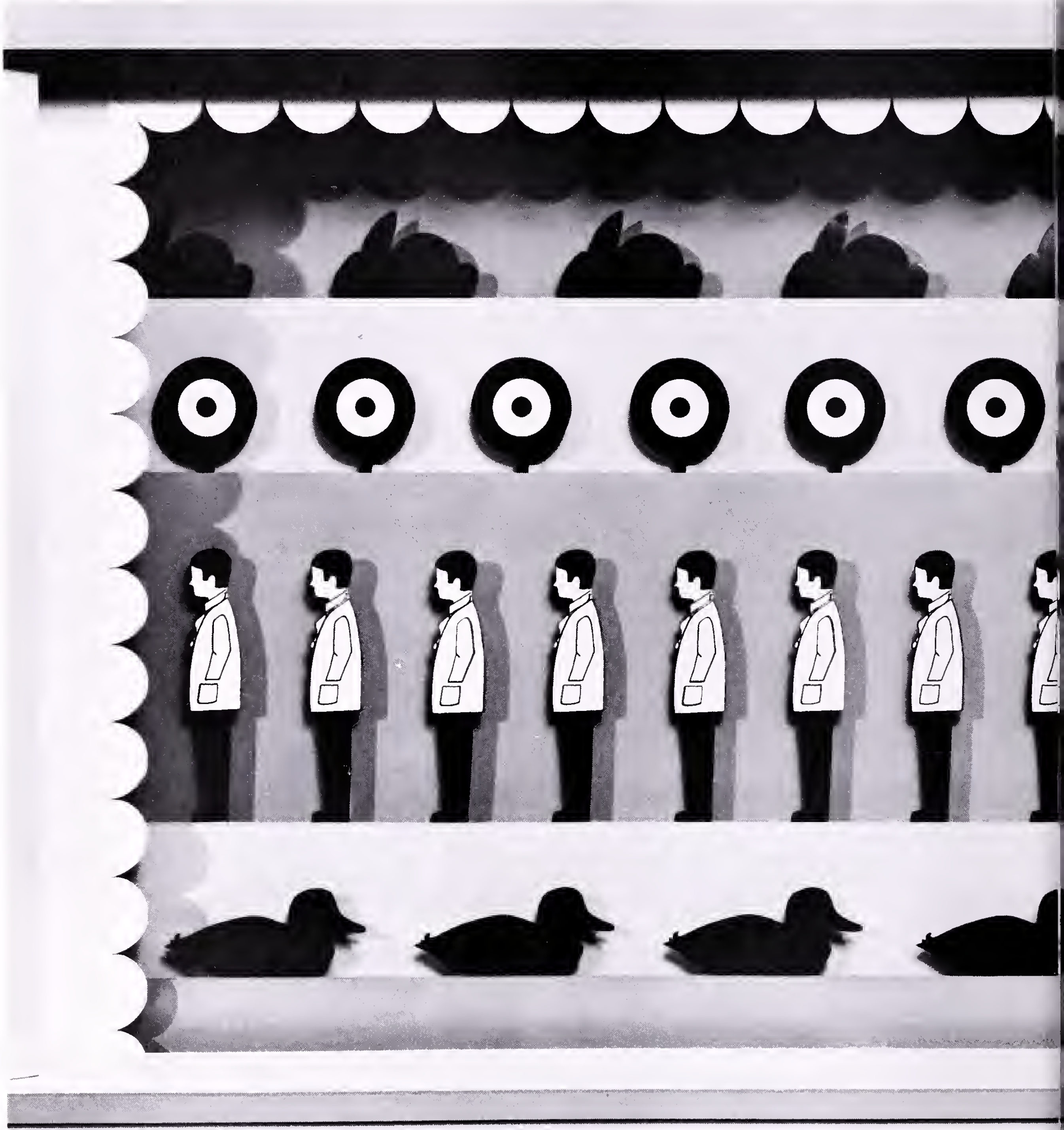
Android®/5 mg. Buccal/10 mg. Oral/25 mg Oral

Methyltestosterone U.S.P. Tablets

ANDROID®/F

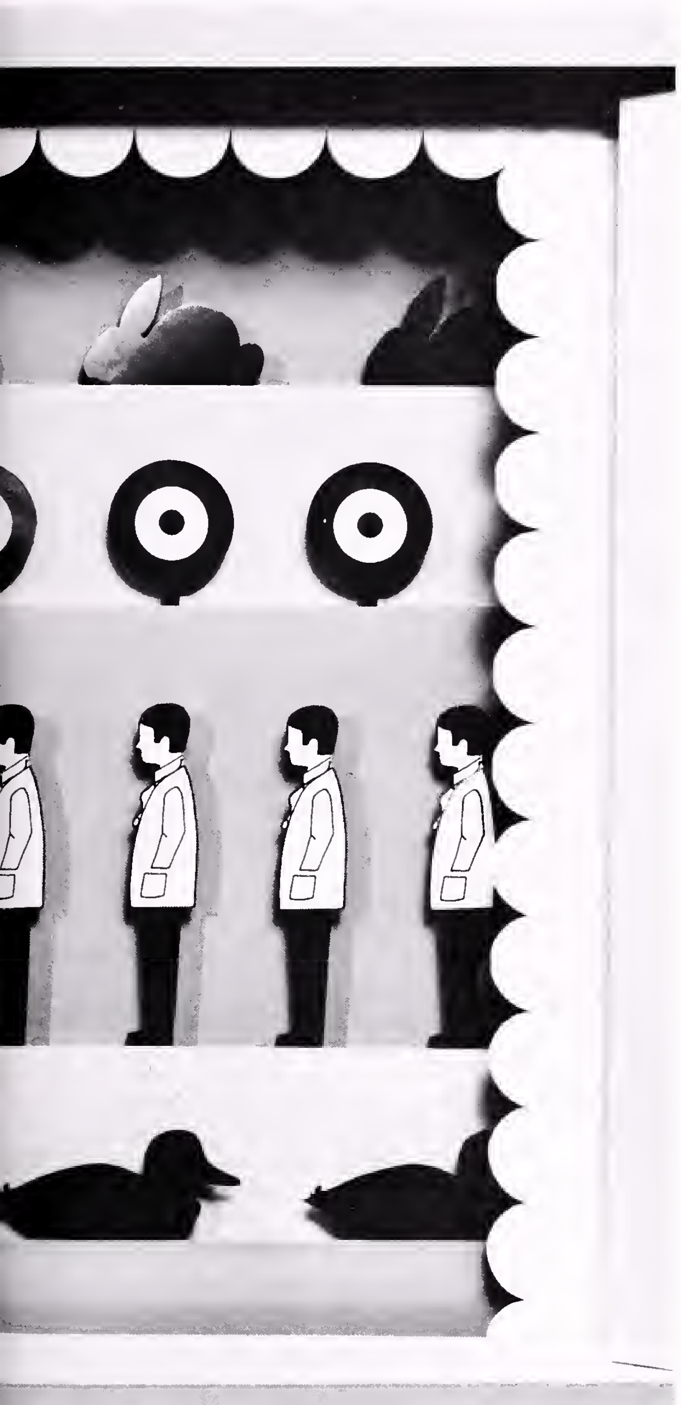
Fluoxymesterone U.S.P. Tablets, 10 mg.

If you become the target of



©1983 MPMLC

rofessional liability claim...



You will be glad you have Michigan Physicians.

Michigan Physicians has been solving complex medical professional liability problems since 1976. With the state's largest and most experienced claims staff, Michigan Physicians works with you to resolve claims (and incidents) that most physicians have never faced in their careers.

In a changing legal environment, you need the best coverage you can buy because the risk of a professional liability claim is becoming greater every day.

For a confidential rate quotation and more information about Michigan's leading physician-owned insurance company, call or write the office in your area.

Michigan Physicians
Mutual Liability Company

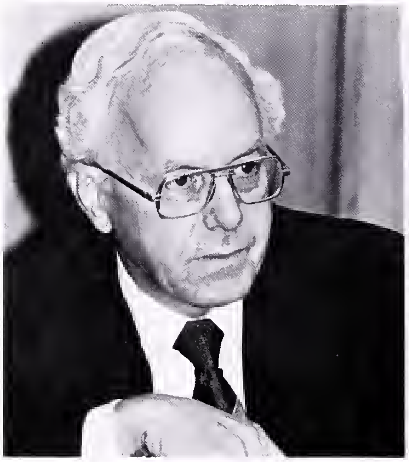
1305 Abbott Road
East Lansing, MI 48823
(517) 351-1150
(800) 292-1926

6735 Telegraph Road
Suite 205
Birmingham, MI 48010
(313) 647-5550

Endorsed by the Michigan State Medical Society

At the helm
since September 1,
Ambrose intends
to “stay the course” —
with a few changes

Following
New MSMS Exe



MSMS members can expect more conferences on crucial issues and more useful, pertinent literature from their state society, says new Executive Director Bruce W. Ambrose.

Ambrose, former deputy director and manager of government relations, assumed the top staff post Sept. 1 on the retirement of Warren F. Tryloff.

“The medical society's greatest concern,” discloses Ambrose, “should be helping MSMS members to the information and logic they need in a time of great change. If MSMS can make the necessary facts available to its membership, they can make individual and personal decisions to cope with those changes.”

“We're developing a very intensive effort to keep the members informed,” says Ambrose. He cited one of the objectives of the new MSMS Strategic Plan he feels is especially topical:

“To educate and sensitize MSMS members about the nature of competition and its various forms, its effect on patient care, and the individual physician's options under various conditions.”

“We have seen recent developments that will have a profound effect on the future. Our emerging knowledge about the health care benefits part of the new General Motors and Ford labor contracts impart a heavy reliance on alternative health care delivery systems.

“We must help our members in heavy GM population areas to cope with a new intensity of change. As we gather information, we have to pass it on to our membership in a variety of forms.

“We cannot tell them what to do, but we can make sure they know the options, and the responsibilities that go with all the options.”

A different style

The silver-haired, brown-eyed Ambrose spoke earnestly for *Michigan Medicine* from his new office in the southeast corner of MSMS headquarters. He was deep into staff reorganization plans as he reflected.

“I think the major contribution I can make as executive director,” he said, “will be in helping the organization become accustomed to a different style of staff leadership after 15 years of excellent leadership by Warren Tryloff.”

“How does he plan to accomplish this task?

“By just being myself,” he says candidly. “I have confidence that I can be a competent leader.

“I have new responsibilities. I have to get used to them, and the members have to get used to my handling them. But I'm confident this will happen.”

Ambrose has high praise for his predecessor Tryloff.

“This organization has been more fortunate than it realizes in its staff leadership,” he says. “Warren is as good as, and probably better than, any association executive I've ever had to deal with.

“Yes, it's a difficult task to succeed anyone that successful and well-liked,” says Ambrose. “But on the other hand, the program has been run so well, there's no need for great change. Nothing has to happen immediately, or even in the immediate future. The

By Judith Marr, Editor

ough act:
ruce Ambrose

wheels are turning, so I benefit."

Before Ambrose joined the MSMS staff in 1970 to head government relations activities he had the same responsibility for the Michigan Society for Mental Health. He has maintained an active volunteer association with the MHAM.

Commendations

MSMS staff members have become accustomed to hearing their new executive director commended by legislators, lobbyists, government health care agency staff and government relations directors of other state associations.

"You have one of the best organization representatives in Bruce Ambrose," testified State Sen. William Sederburg (R-Lansing) to MSMS staff on a tour of the state Capitol building this summer. "He is among the most honest, helpful and prepared of all the lobbyists we meet."

Bruce's outspoken relish for his government relations work and

Continued on next page

A personal glimpse

"You consider Bruce Michigan State Medical Society. We consider him Mental Health Association. We love Bruce: he's the kind of volunteer we all want."

This is the warm assessment Beth Leeson makes of new MSMS Executive Director Bruce Ambrose's contributions to the Mental Health Association in Michigan. Leeson is MHAM Public Policy Coordinator.

Ambrose's current volunteer work to better Michigain citizens' mental health is one of the greatest of his interests.

He served as a lobbyist for the Mental Health Association for 10 years prior to joining MSMS in 1970, and was instrumental in drafting and obtaining passage of the Community Mental Health Services Act of Michigan (PA 54 of 1963). He was association president in 1982-83, and executive committee chairman in 1980-81.

Before his Mental Health Society days, Ambrose worked as a reporter and copy desk editor for 14 years on newspapers in Michigan, New York and Ohio. He is a history graduate of Western Michigan University and a native of Carson City.

Since joining MSMS in 1970, Ambrose served as manager of the Department of Government Relations. While in that position, he played a key role in the adoption of the Medical Practice Act, and the 14-bill package to alleviate the medical malpractice insurance availability crisis.

He was named MSMS deputy director in 1983.

Ambrose belongs to the American Society of Association Executives and to the American Association of Medical Society Executives.

He is an avid reader, particularly of history books and mysteries. He has traveled most of America and to England, Europe, Japan and Hong Kong.

Ambrose also is a devoted Tiger baseball fan who once served as coach of an MSMS staff softball team under the pseudonym of "Blackjack." He has been known to send Kevin Kelly, his successor as manager of the MSMS Government Relations Department, confidential inner-office predictions of the Tigers win-loss record.

On long drives home from MSMS evening meetings during Tiger season, staffers can count on hearing Ernie Harwell full blast on the car radio.

"You can't hear yourself think," reports Kelly, who has been a captive listener more than once. "But as a junior staff member, you certainly can't ask to turn the radio down. That would be sacrilege."

Ambrose and his wife of 38 years, Betty, enjoy their country home near Lansing and their annual vegetable garden. Betty is a retired elementary school teacher.

Together they have raised five children — Edwin (Ed), a computer programmer in Mason; Kathryn (Kitty) Ambrose Miller, director of financial aid for a private school in Denver; Jonathon (Jock), swim coach at Kentwood High School; Martin (Marty), second year internal medicine resident at Indiana University Hospital, and Carolyn, a Lansing-area retailer.

In addition, the Ambroses are the grandparents of four girls and one boy. ☐

the great energy he put into it led staff to label it "the glamour arm" of the medical society.

"It is difficult to leave something you've thoroughly enjoyed doing and in which you have achieved some successes," he admits. "I enjoy people who like to work in government — the politicians, the civil servants.

New MSMS Executive Director Bruce Ambrose, left, and Managing Director William Madigan.

"But this new position is the opportunity to conclude a career with relish over the next several years. It is an exciting challenge and a time to move ahead."

When Warren Tryloff retired from active MSMS service, the society announced that Ambrose would serve as executive director and William E. Madigan would become managing director. The latter is a new position, and Ambrose describes the division of duties thus:

"Over the last several years, this medical society, like most state medical associations, has expanded dramatically in members and activities. Medical economics also have become turbulent and dynamic.

"This medical society has been wisely advised to spread some of its activities into other organizations, such as the Physician Service Group, Physicians Review Organization of Michigan and the Michigan Foundation for Medical Education and Research, which do things for members that MSMS cannot do.

"Since I've been with MSMS, I've seen its budget and staff more than double in size. So it's wise to have both executive and managing directors."

Ambrose is the association's CEO, and deals primarily with officers and external forces. Madigan is chief of operations and deals with internal affairs and staff.

Ambrose's CEO duties include serving as advisor and MSMS consultant to PROM, as executive vice president to PSG, and working with the foundation. He works with MSMS leadership to successfully achieve the objectives of the new strategic plan. He is responsible for planning, for advising on courses of action to fit the directives from the House of Delegates, and for dealing with decision-making processes.

Of Madigan's charge, he says, "Bill's duties are to make the Michigan State Medical Society work and work well. Tactics belong to him — operations of MSMS, staff supervision, internal affairs, board and House of Delegates functions. Bill is an excellent choice for the assignment, and we are working closely as an executive team."

All staff ultimately report to Ambrose. "If they slip, I fall," he acknowledges.

The new Strategic Plan focuses MSMS efforts for the immediate future, reinforcing the long-range planning which took place two years ago. It identifies 13 areas of primary concern to Michigan physicians.

"We still are developing tactics to carry out the objectives in the plan," says Ambrose. He expects to see the Strategic Plan updated every two years or so.

"We seem to be moving, with other associations, toward this how-to focus," he observes. "But consider the ambience we're living in right now. The economics of health care delivery are more turbulent, subject to more change faster, than observers have seen in many years. There is the increase in numbers of physicians and changes in the method of reimbursement. Much is different and new."

In the major areas of physician concern such as malpractice, health care costs, physicians' public image and the growth of alternative delivery systems, as well as physician numbers and reimbursement changes, MSMS has continuing programs, he points out.

"I don't know how much we can influence the increment in numbers of physicians," he says. "But we are active in the Michigan Council for Graduate Medical Education."

"We've poured thousands of dollars and hours into the professional liability problem," he reminds.

"Our Department of Medical Economics and Reimbursement is in such demand we have difficulty meeting county and specialty society requests for information and help."

Ambrose hopes to visit every county medical society in the state, and will be as open as possible to the members, he says.

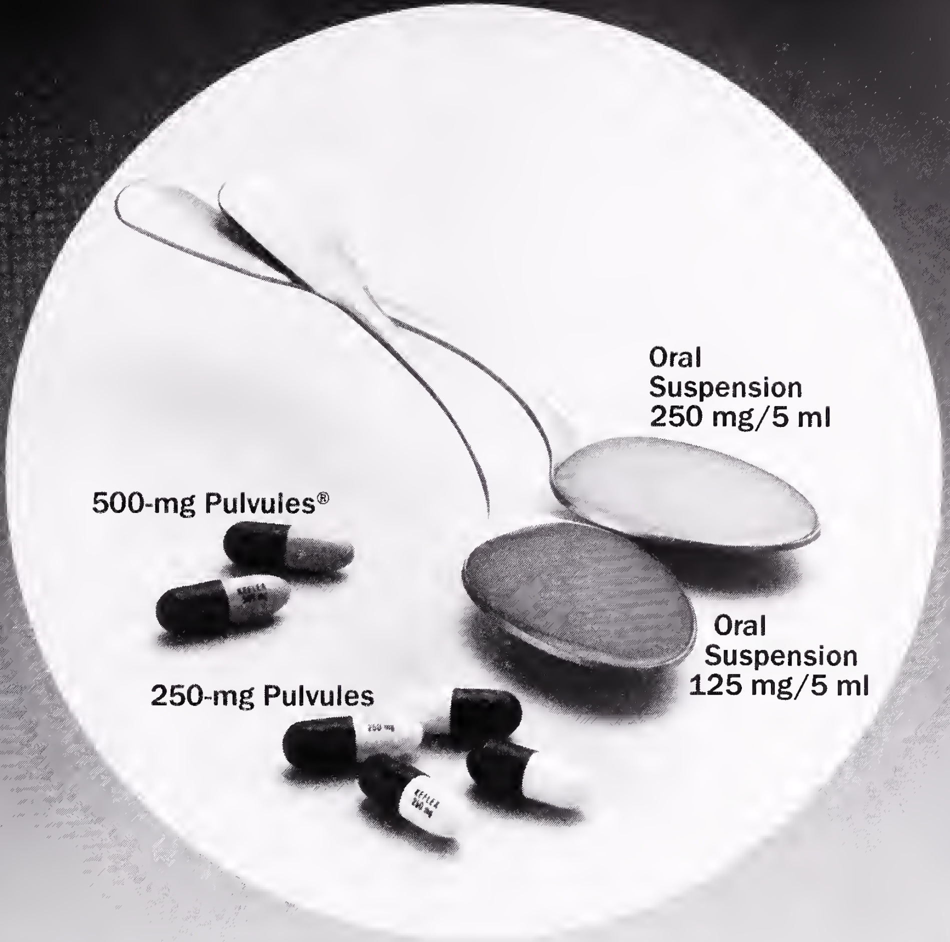
"It's been my style of life to be open, and it has succeeded so far," he says. "I certainly hope that any physician who wants to talk to me will pick up the phone."

He sees the county medical societies as "the bedrock of organized medicine."

Bruce Ambrose declares he is happy with his new position as staff head of the Michigan State Medical Society.

"This is an important job with an important organization. Not everybody gets here." ☐

Easy To Take


Oral
Suspension
250 mg/5 ml
500-mg Pulvules®
Oral
Suspension
125 mg/5 ml
250-mg Pulvules

Keflex®
cephalexin

Additional information
available to the profession
on request.

DISTA
420113

Dista Products Company
Division of Eli Lilly and Company
Indianapolis, Indiana 46285
Mfd. by Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

Leaders attend malpractice briefing

What to do about the medical malpractice climate in Michigan, with its rising settlements and increasing numbers of claims filed, was the subject when 25 interested physicians met Oct. 10 at MSMS headquarters. They were summoned by Louis R. Zako, MD, MSMS president, who invited them to vent their frustrations and then to move to solution. "I'm charged," Doctor Zako said, "with bringing the elements of the malpractice situation together in a cohesive whole."

The group reached concensus on a four-point approach to the Michigan medical malpractice situation. (The four points are outlined in the October 18 *Medigram.*)

"This is not a cosmetic meeting," said Doctor Zako. "We all feel too strongly to put on a showcase and not do anything. MSMS may not be able to ameliorate the problem, but we must try."

More photos on page 584

$EMINAR$

*FINANCIAL SEMINARS FOR MEDICAL PROFESSIONALS

1984-85 SERIES BY WORLDWIDE FINANCIAL SEMINARS, INC.

Seminars held in **Orlando, Florida at the new, luxurious Hilton at the **Walt Disney World** Village Hotel Plaza (special Seminar room rate).

Two full Thursday and Friday morning sessions throughout the year. Pick your own dates.

FOR SEMINAR INFORMATION, WRITE OR CALL *COLLECT;*
The Benn Group,
1118 Knights Place,
Lakeland, FL 33803, (813) 646-3892

**The financial Seminar program is designed to comply with Federal tax law regarding tax deductibility.*

Staff comprised of highly qualified investment, financial planning, managed account specialists/authors from leading international investment firm.

***Year-round Area Attractions — Walt Disney World • Sea World • Cape Canaveral • Beaches • Golf • Tennis • Swimming • Deep Sea Fishing*

OBESITY.

THE CONSEQUENCES CAN BE LIFE-SHORTENING.

As physicians, every one of us knows the consequences of obesity: cardiovascular disease. . . diabetes. . . hypertension. . . congestive heart failure. . . an increased risk of sudden death.

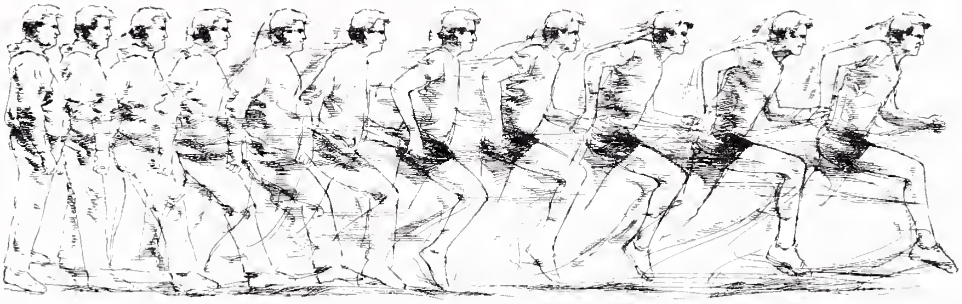
Most of us also recognize how difficult it is for the obese patient to lose weight, not to mention the frustrations and failures that attend long-term maintenance of normal weight.

The Institute for Health Maintenance (IHM) can help.

Working in conjunction with a patient's primary care physician, IHM offers a medically sound regimen for therapeutic weight loss: THE RISK FACTOR OBESITY PROGRAM (RFO).

Developed under clinical conditions at major medical teaching institutions, the RFO Program combines a medically supervised supplemented fast with long-term behavioral and nutritional training.

Under the supervision of physicians and their staff, patients lose weight safely and consistently over a period of weeks and months, receiving their total daily nutritional requirements from a low-calorie egg albumen formulation supplemented with potassium and vitamins.



The success of the RFO Program has been significant.

Over the past five years, more than ten thousand patients have lost from 25 to over 400 pounds, with an average weight loss of 63 pounds. More important, 50% of patients admitted to our program have been able to sustain their new low weight levels for one year with the help of long-term maintenance.

Some patients have called the RFO Program "life-saving." As physicians, we know the relationship between certain risk factors and longevity. Obesity is one of those factors—one we can help reduce.

To learn more about us and how this program can safely benefit some of your patients, please contact University Health Center, 4201 St. Antoine, Detroit, Michigan 48201. (313) 832-2460.

The Risk Factor Obesity Program

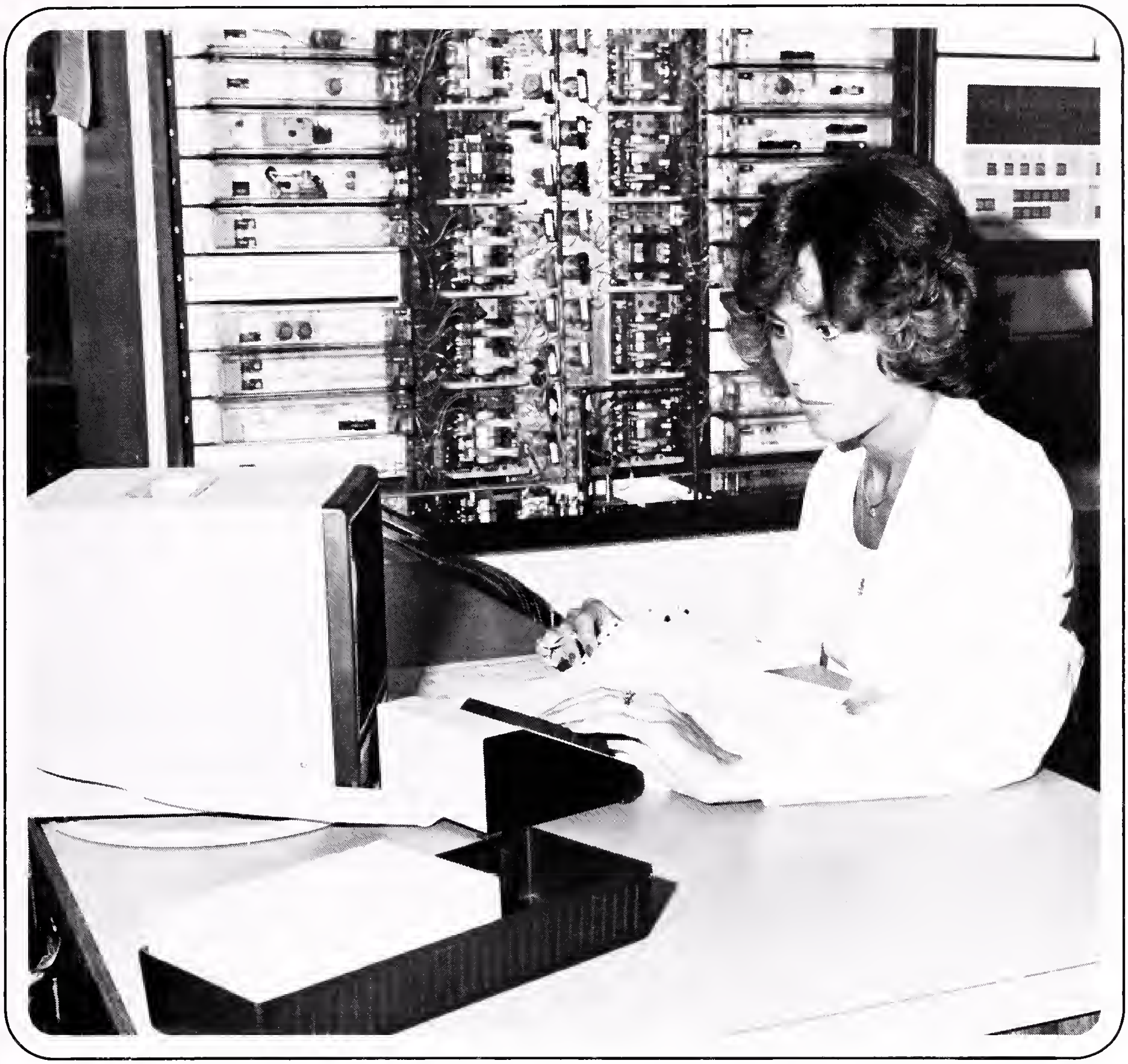
Medically designed. Medically supervised. Medically sound.

Doctor Mandell, left, and MSMS President-elect Richard J. McMurray, MD, conferred as participants around the boardroom table at MSMS headquarters described their views of the malpractice situation.

"There's a lot of legal activity out there and it isn't getting any better," said Robert M. Leitch, MD, left, president of the Michigan Physicians Mutual Liability Company. Pictured above with Eber Sherman, MD, (seated) and MSMS Speaker Gerald H. Mandell, MD, he called for educating physicians to be more careful in their practices, to thus avoid lawsuits.

MSU medical student Lisa von Miltke, student representative to the MSMS Task Force on Professional Liability, talked before the meeting with orthopedist Michael Parks, MD, South Haven, center, and thoracic surgeon John L. Shek, MD, Saginaw.

"It's naive to think malpractice costs will come down," said Rhoda M. Powsner, MD, Ann Arbor, right, "but we are trying to keep them from going up." She called for support of the Michigan Medical Arbitration Program as the best available vehicle for doing that. In closing the meeting, Doctor Zako, left, gained concensus from the group to support arbitration, study voluntary physician defense panels, lower the incidence of malpractice, look at alternatives to the present system.



Technicon Smac

General Chemistry: Advance Medical & Research Center, Inc., employs the latest in sophisticated automation in the performance of routine blood chemistry determinations. This allows for the greatest consistency in quality assurance of results while utilizing the least amount of patient specimen.

ADVANCE MEDICAL & RESEARCH CENTER, INC.

1270 Doris Rd. • Pontiac, Michigan 48057 • (313) 373-9120

Branches: Allen Park, Alpena, East Jordan, Flint,
Grand Rapids, Kalamazoo, Lansing, Monroe, Traverse City

Serving the medical profession since 1963

Controversy and change

By Carole Eberly

Senator Henry predicts the health care industry's future

Sen. Paul Henry

Controversial and changing times are ahead for the health care industry, the chairman of the state Senate Committee on Education and Health has predicted.

Senator Paul Henry, a Grand Rapids Republican who at the time of this writing was running for a congressional House seat, said third party reimbursement is just one area that will be examined.

"I'm convinced the whole means by which we now have reimbursement is going to change," he said. "You're looking at HMOs as an alternative, PPA-type arrangements, reinstitution of substantial up-front deductibles for lower costs — all these things are out there."

State health plan

Other controversial health care issues will come up in a recently completed state health plan. The plan, three years in the drafting, covers such areas as the supply of physicians and what it will mean to medical education funding, licensure of all medical professionals, enforcement of complaints against physicians, cost containment and preventative health.

"Once it leaves this legislature, it becomes the broad policy document of the state of Michigan," Henry said. The plan now is awaiting action in the House. After its approval and/or modification, it will be sent on to the Senator's committee for action. Henry is hopeful it will go into effect by the first of next year.

In another area, he said lawmakers will have to decide how to deal with reimbursement to free-standing clinics as opposed to non-free-standing ones.

He said no matter what lawmakers do with the controversial issues coming up, they're not going to please everyone.

"And that is why it's critically important that communications remain open," he added. He said just because one issue may not go the way one segment of the health care community wants it to, lawmakers and the various health care groups must not become angry and decide they're not on speaking terms anymore.

"That would be the worst thing that could happen," he said. "I'm a firm believer that virtually all advocates generally mean well. Open and honest communication can at least reduce the problems to problems that are understood, rather than mistaken."

MD Advisory committee

Henry, who served in the Michigan House from 1979-82 until being elected to the Senate in 1983, acknowledged much of his understanding of physicians' views of medical issues comes from meetings with Kent County physicians.

"Maybe I'm spoiled in that we have a very strong advisory committee in Kent County that meets on a regular basis with legislators," he said. "And that has proved to be very, very helpful." He said part of the success of the group is that meetings are called only when an issue of importance is at hand. Henry suggested that other similar groups would be wise to insure that each lawmaker have at least one physician whom he or she could confide in. But, he emphasized that not all physicians agree on all issues any more than all legislators do.

He added that an important part of working together is not simply to speak out and leave "but also to reconcile and heal

Continued on page 588

Ms. Eberly is a Lansing-area freelance writer.

*When your practice requires your undivided medical attention, it's nice having a **Specialist** handling your non-medical worries.*

*The **Specialist**.*

Medical Billing, Practice Productivity Analysis, Appointment Scheduling and much more.

Key System Features

- *Multi-user/Multi-work station*
- *IBM reliability*
- *Expandable, as your practice grows*
- *60 day full refund policy*
- *Automatic input into the Blue Shield system*
- *Custom insurance form generation*
- *Family and individual account detail*
- *Password protected information*

Make the Specialist your total office management resource.

MMCA MINI MICRO **COMPUTER APPLICATIONS, INC.**

I am interested in more information on the ***Specialist.***
Please provide additional details.

Name ______________________
Address ______________________
City ______________ State ________ Zip ________
No. of Physicians in practice ________
Physician Specialty ______________

MMCA MINI MICRO COMPUTER APPLICATIONS, INC.
1383 Woodward Avenue, Suite 204
Bloomfield Hills, MI 48013
(313) 335-1400

HENRY/Continued from page 584

— to bring together opposite points of view."

PPA legislation

One of the stickier issues facing Lansing lawmakers now is the PPA (Prudent Purchaser Arrangement) legislation. Passed earlier in the Senate, the eight-bill package was then amended in the House to allow insurance agencies to form Political Action Committees (PACs). Because the Senate refused to accept the change, the legislation was sent to a special Senate-House conference committee to see if an agreement could be ironed out. Henry said the issue has been "brought to a grinding halt" and will stay that way "until that political impasse can be resolved and final passage of the package" can occur.

Senator Henry met with the Michigan Doctors Political Action Committee (MDPAC) Sept. 5 at MSMS headquarters.

However, no predictions were made on the fate of the package.

"I'm sure there are some people who feel this is a nice way to kill the whole package," he said. "And there are others who are saying if you're going to kill it, this is the wrong way to do it."

Henry voted for passage of the Senate version, but voted against the House bill with the PAC provision.

Crucial issues

What does Henry see ahead as the most crucial health care issue?

"I would say the major issues that are really coming down are in the way the state is being impacted by change at the federal level," he said.

He cited as examples the great deal of talk earlier this year about construction limitations, construction capitations and certificate of need review processes.

"And I would argue that the DRG reimbursement system in many respects has transformed the economic climate in the way hospitals are financed, and may in fact substantially alter the way in which hospitals commit themselves to capital expansion," he said.

He said federal Medicaid and Medicare procedures and the degree to which physicians are potentially reimbursed differently under pending Washington legislation has a profound impact not only "on the so-called cost savings elements, but on terms of patient freedom of choice."

"Can we say that potentially this creates problems just as we've had problems with the few who've exploited Medicaid?" he asked. "Will this yield to a kind of exploitation in the Medicare area?"

Scope of practice

On the scope of practice issue, Henry said that is always a very difficult matter to deal with.

"You always have to ask yourself to what extent are we really protecting the legitimate interests of the consumer," he said. "Are limitations on scope of practice arbitrary limitations which are really meant to give monopolistic preference to certain providers or are the limitations to protect the consumer — to insure that those who are providing the service receive qualified and proper training."

Henry thought a satisfactory solution to the perennial issue of optometry and ophthalmology was resolved to the satisfaction of both groups this past legislative session. In that issue optometrists were given the right to limited use of dignostic drugs if they had the proper training. However, therapeutic use was strictly prohibited.

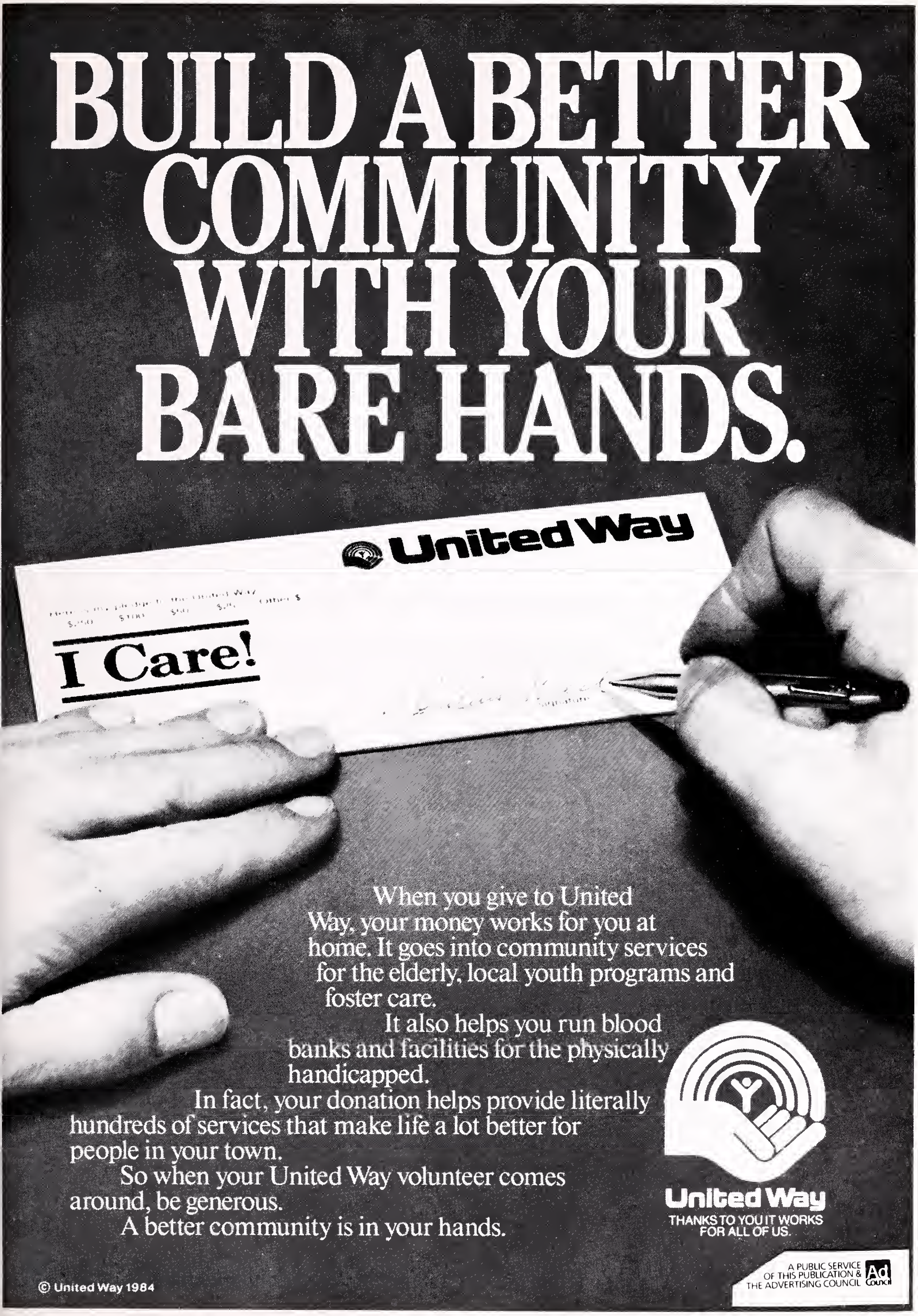
Legislative climate

Henry took over as head of the Committee on Health and Education in the 38-member Senate following last February's GOP takeover of the chamber when two Democrats were ousted in special elections on the state income tax issue. What change has this had on the Senate?

"Republicans are more concerned about freedom of choice for the consumer and a multiplicity of health care options," Henry maintained.

"We are a little more resistent to some kind of central state plan — that is viewing some kind of state plan as a once-and-for-all fixing of the system.

"My personal feeling is today's reform is tomorrow's problem," he added. "We have to keep an open view and realize that in areas complex as this we're seeking proximate solutions to insoluble problems." ☐



BUILD A BETTER COMMUNITY WITH YOUR BARE HANDS.

When you give to United Way, your money works for you at home. It goes into community services for the elderly, local youth programs and foster care.

It also helps you run blood banks and facilities for the physically handicapped.

In fact, your donation helps provide literally hundreds of services that make life a lot better for people in your town.

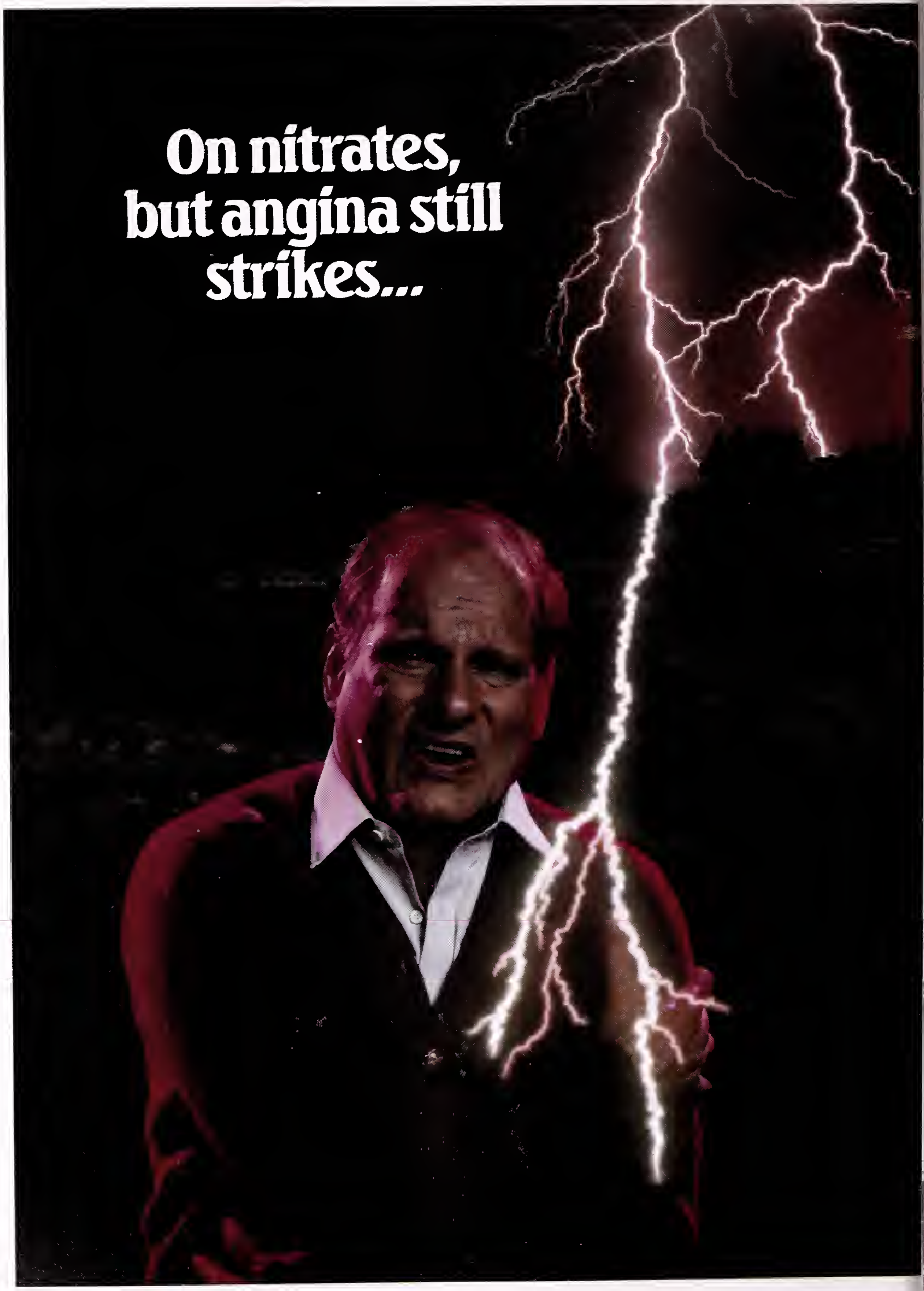
So when your United Way volunteer comes around, be generous.

A better community is in your hands.

United Way
THANKS TO YOU IT WORKS
FOR ALL OF US.

A PUBLIC SERVICE
OF THIS PUBLICATION &
THE ADVERTISING COUNCIL Ad Council

© United Way 1984


On nitrates,
but angina still
strikes...

After a nitrate, add ISOPTIN®

(verapamil HCl/Knoll)

To protect your patients, as well as their quality of life, add Isoptin instead of a beta blocker.

First, Isoptin not only reduces myocardial oxygen demand by reducing peripheral resistance, but also increases coronary perfusion by preventing coronary vasospasm and dilating coronary arteries — both normal and stenotic. These are antianginal actions that no beta blocker can provide.

Second, Isoptin spares patients the beta-blocker side effects that may compromise the quality of life.

With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin... for more comprehensive antianginal protection without side effects which may cramp an active life style.

ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page.

ISOPTIN® TABLETS
(verapamil HCl/Knoll)
80 mg and 120 mg

Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction <30%) or moderate to severe symptoms of cardiac failure. Control milder heart failure with optimum digitalization and/or diuretics before ISOPTIN is used. ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild, and controlled by decrease in ISOPTIN dose). Occasional elevations of liver enzymes have been reported; patients receiving ISOPTIN should have liver enzymes monitored periodically. Patients with atrial flutter/fibrillation and an accessory AV pathway (e.g., W-P-W or L-G-L syndromes) may develop a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion. AV block may occur (3rd degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema, and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with ISOPTIN. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, patients should be monitored closely. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function or in patients who have also recently received methyldopa. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patient carefully monitored. ISOPTIN may have an additive hypotensive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR<50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%). The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: confusion, paresthesia, insomnia, somnolence, equilibrium disorders, blurred vision, syncope, muscle cramps, shakiness, claudication, hair loss, maculae, and spotty menstruation. Overall continuation rate of 94.5% in 1,166 patients. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in 80 mg and 120 mg sugar-coated tablets. July 1982 2068

knoll® **KNOLL PHARMACEUTICAL COMPANY**
30 NORTH JEFFERSON ROAD, WHIPPANY, NEW JERSEY 07981

2195

TRUTH

When the North Atlantic Treaty Organization was formed in 1949, it was formed for one reason. To stop Soviet aggression in Europe.

TRUTH

The Warsaw Pact's conventional fighting capabilities far exceed that of European NATO forces.

TRUTH

In order to maintain peace and freedom in Europe, NATO has effectively maintained a policy of deterrence with the Soviet Union.

TRUTH

The past 35 years of peace have been one of the longest periods of European peace in recorded history.

TRUTH

The Soviets will not risk war. Unless they are sure they can win.

NATO.

We need your support.
And the truth is, you need ours.

Ad Council *A public service message from this magazine and the Advertising Council.*

Motrin reduces inflammation, pain ...and price

New low price...major savings

The dramatic reduction in the price of *Motrin* Tablets means substantial savings from now on for your patients and for patients all across the country for whom *Motrin* Tablets are prescribed.

Motrin is priced lower than Clinoril, Feldene, or Naprosyn.

The price of *Motrin* Tablets to pharmacies has been reduced as much as 35%. Patients taking the average dosage should now pay less for therapy with *Motrin* Tablets than for almost any other nonsteroidal anti-inflammatory drug you prescribe...less, for example, than for Clinoril, Feldene, or Naprosyn. And, of course, all strengths of *Motrin* Tablets continue to be available by prescription only.

Please turn the page for a brief summary of prescribing information.

Motrin® 400 & 600 mg TABLETS
ibuprofen

Good medicine...good value

© 1984 The Upjohn Company

The Upjohn Company Upjohn Kalamazoo, Michigan 49001

Motrin® Tablets (ibuprofen)

Contraindications: Anaphylactoid reactions have occurred in individuals hypersensitive to *Motrin* Tablets or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin, iodides, or other nonsteroidal anti-inflammatory agents.

Warnings: Peptic ulceration and GI bleeding, sometimes severe, have been reported. Ulceration, perforation and bleeding may end fatally. An association has not been established. Use *Motrin* Tablets under close supervision in patients with a history of upper gastrointestinal tract disease, after consulting ADVERSE REACTIONS. In patients with active peptic ulcer and active rheumatoid arthritis, try nonulcerogenic drugs, such as gold. If *Motrin* Tablets are used, observe the patient closely for signs of ulcer perforation or GI bleeding.

Chronic studies in rats and monkeys have shown mild renal toxicity with papillary edema and necrosis. Renal papillary necrosis has rarely been shown in humans treated with *Motrin* Tablets.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue *Motrin* Tablets and the patient should have an ophthalmologic examination, including central visual fields and color vision testing.

Fluid retention and edema have been associated with *Motrin* Tablets; use with caution in patients with a history of cardiac decompensation or hypertension. In patients with renal impairment, reduced dosage may be necessary. Prospective studies of *Motrin* Tablets safety in patients with chronic renal failure have not been done.

Motrin Tablets can inhibit **platelet aggregation** and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and on anticoagulant therapy.

Patients should report signs or symptoms of **gastrointestinal ulceration** or bleeding, skin rash, weight gain, or edema.

Patients on prolonged **corticosteroid therapy** should have therapy tapered slowly when *Motrin* Tablets are added.

The antipyretic, anti-inflammatory activity of *Motrin* Tablets may mask inflammation and fever.

As with other nonsteroidal anti-inflammatory drugs, borderline elevations of liver tests may occur in up to 15% of patients. These abnormalities may progress, may remain essentially unchanged, or may be transient with continued therapy. Meaningful elevations of SGPT or SGOT (AST) occurred in controlled clinical trials in less than 1% of patients. Severe hepatic reactions, including jaundice and cases of fatal hepatitis, have been reported with ibuprofen as with other nonsteroidal anti-inflammatory drugs. If liver disease develops or if systemic manifestations occur (e.g. eosinophilia, rash, etc.), *Motrin* should be discontinued.

Drug interactions. *Aspirin:* used concomitantly may decrease *Motrin* blood levels.

Coumarin: bleeding has been reported in patients taking *Motrin* and coumarin.

Pregnancy and nursing mothers: *Motrin* should not be taken during pregnancy or by nursing mothers.

Adverse Reactions: The most frequent type of adverse reaction occurring with *Motrin* is gastrointestinal of which one or more occurred in 4% to 16% of the patients.

Incidence Greater than 1% (but less than 3%)—Probable Causal Relationship

Gastrointestinal: Nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence); **Central Nervous System:** Dizziness,* headache, nervousness; **Dermatologic:** Rash* (including maculopapular type), pruritus; **Special Senses:** Tinnitus; **Metabolic/Endocrine:** Decreased appetite; **Cardiovascular:** Edema, fluid retention (generally responds promptly to drug discontinuation; see PRECAUTIONS).

Incidence less than 1%—Probable Causal Relationship**

Gastrointestinal: Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, melena, gastritis, hepatitis, jaundice, abnormal liver function tests; **Central Nervous System:** Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma; **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia; **Special Senses:** Hearing loss, amblyopia (blurred and/or diminished vision, scotomata, and/or changes in color vision) (see PRECAUTIONS); **Hematologic:** Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit; **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations; **Allergic:** Syndrome of abdominal pain, fever, chills, nausea and vomiting; anaphylaxis; bronchospasm (see CONTRAINDICATIONS); **Renal:** Acute renal failure in patients with pre-existing significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria; **Miscellaneous:** Dry eyes and mouth, gingival ulcer, rhinitis.

Incidence less than 1%—Causal Relationship Unknown**

Gastrointestinal: Pancreatitis; **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri; **Dermatologic:** Toxic epidermal necrolysis, photoallergic skin reactions; **Special Senses:** Conjunctivitis, diplopia, optic neuritis; **Hematologic:** Bleeding episodes (e.g., epistaxis, menorrhagia); **Metabolic/Endocrine:** Gynecomastia, hypoglycemic reaction; **Cardiovascular:** Arrhythmias (sinus tachycardia, sinus bradycardia); **Allergic:** Serum sickness, lupus erythematosus syndrome, Henoch-Schonlein vasculitis; **Renal:** Renal papillary necrosis.

*Reactions occurring in 3% to 9% of patients treated with *Motrin*. (Those reactions occurring in less than 3% of the patients are unmarked.)

**Reactions are classified under *"Probable Causal Relationship (PCR)"* if there has been one positive rechallenge or if three or more cases occur which might be causally related. Reactions are classified under *"Causal Relationship Unknown"* if seven or more events have been reported but the criteria for PCR have not been met.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis. Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Do not exceed 2400 mg per day. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary.

Caution: Federal law prohibits dispensing without prescription. MED B-7-S

Motrin is a registered trademark of The Upjohn Manufacturing Company

Upjohn The Upjohn Company
Kalamazoo, Michigan 49001

J-4791 August, 1984

Ad Council
U.S. Department of Transportation
DRINKING & DRIVING CAN KILL A FRIENDSHIP.

Ad Council
A Public Service of This Publication.
©1984 The Advertising Council, Inc.

BALANCED CALCIUM CHANNEL BLOCKADE!

CARDIZEM®
(diltiazem HCl)
balances potent coronary vasodilation with a low incidence of side effects

Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:

1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

Please see full prescribing information on following page.

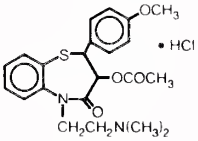
2/84

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral/LD$_{50}$'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD$_{50}$'s in these species were 60 and 38 mg/kg, respectively. The oral LD$_{50}$ in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy** — CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 4/1/84

Another patient benefit product from
PHARMACEUTICAL DIVISION
MARION
LABORATORIES, INC.
KANSAS CITY, MISSOURI 64137

DID YOU KNOW. . .

That the Michigan State Medical Society, along with your insurance administrators, has developed a new group disability insurance plan for MSMS members. This new, improved disability plan is a unique concept in group insurance, offering "your own specialty" definition of disability, residual disability benefits, and many more options. You may now apply for up to $2,500 monthly benefit. This plan offers quality coverage at competitive rates.

In the past, many doctors have feared professional group plans because they were afraid their coverage would be lost if the plan was terminated or if they moved their practice to another state. Let's put an end to this old idea! Your MSMS group disability plan has been in force continuously since 1953 — *with no change in carrier!* But, you still have the guaranteed privilege to convert your group coverage to a policy providing exactly the same benefits and coverage in the unlikely event the policy terminated. You get the same guarantee should you leave the state of Michigan.

Your most valuable asset is your ability to earn an income. Disability insurance is designed to protect that asset. Without adequate income protection, a disability could mean personal hardship and dramatically change your lifestyle. Have you reviewed your coverage lately to determine if you are adequately protected?

If you would like additional information about the Michigan State Medical Society group disability plan and how to apply, please return the form below. This plan is another MSMS member benefit available to you.

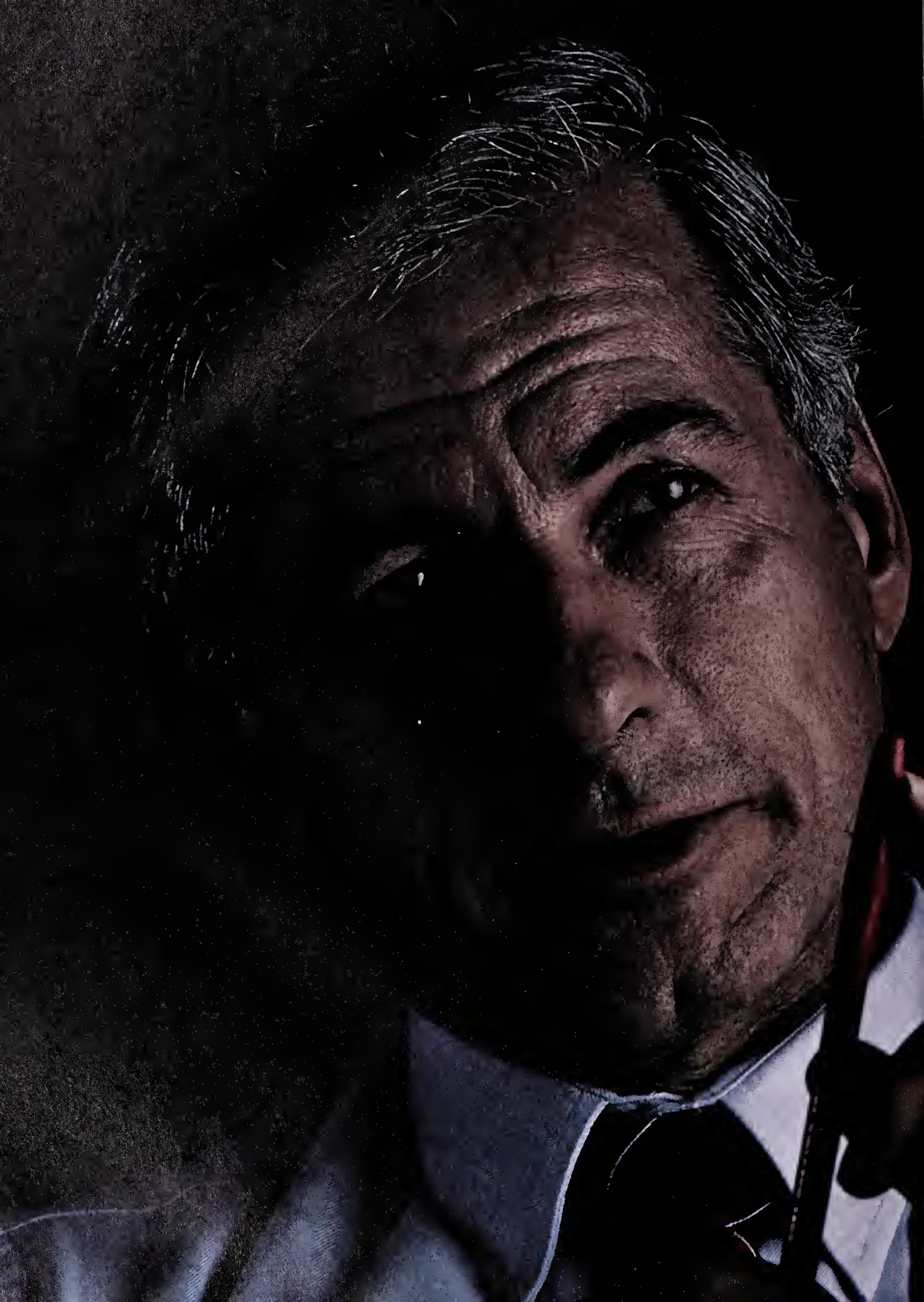
Please send information about the MSMS group disability plan to:

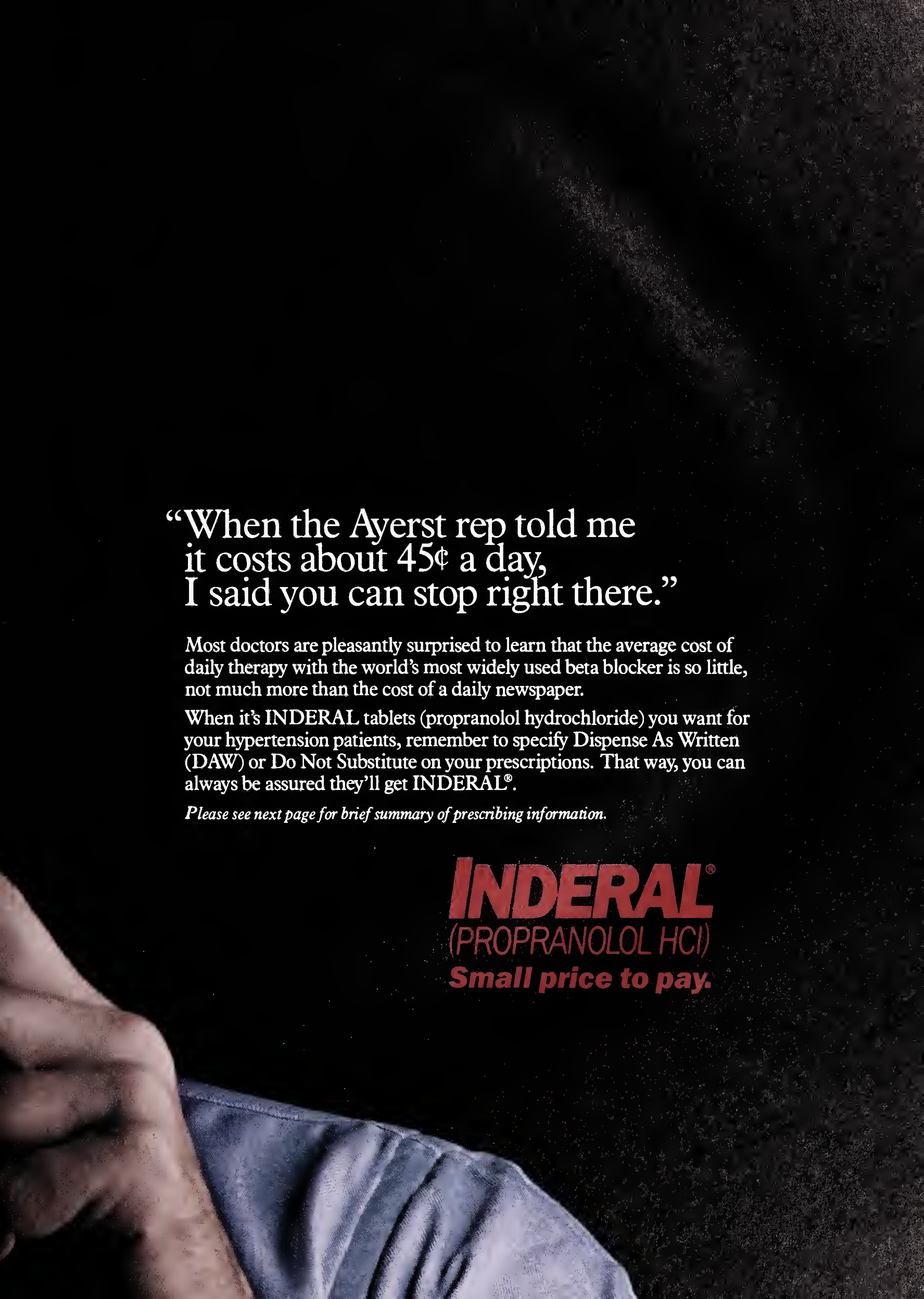
Name: ______________________________

Address: ______________________________

____
City State Zip

Mail form to: Michigan State Medical Society
Group Insurance Plans
P.O. Box 1563
East Lansing, MI 48823





“When the Ayerst rep told me it costs about 45¢ a day, I said you can stop right there.”

Most doctors are pleasantly surprised to learn that the average cost of daily therapy with the world’s most widely used beta blocker is so little, not much more than the cost of a daily newspaper.

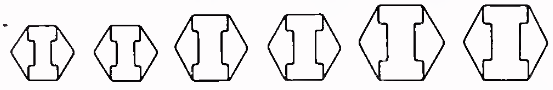
When it’s INDERAL tablets (propranolol hydrochloride) you want for your hypertension patients, remember to specify Dispense As Written (DAW) or Do Not Substitute on your prescriptions. That way, you can always be assured they’ll get INDERAL®.

Please see next page for brief summary of prescribing information.

INDERAL®
(PROPRANOLOL HCl)
Small price to pay.

"When the Ayerst rep told me
it costs about 45¢ a day,
I said you can stop right there."

INDERAL® TABLETS
(PROPRANOLOL HCl)



BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

INDERAL® (propranolol hydrochloride) Tablets

CLINICAL PHARMACOLOGY

The Beta-Blocker Heart Attack Trial (BHAT) was a National Heart, Lung and Blood Institute-sponsored multicenter, randomized, double-blind placebo-controlled trial conducted in 31 U S. centers (plus one in Canada) in 3,837 persons without history of severe congestive heart failure or presence of recent heart failure; certain conduction defects; angina since infarction, who had survived the acute phase of myocardial infarction. Propranolol was administered at either 60 or 80 mg t.i.d based on blood levels achieved during an initial trial of 40 mg t i.d Therapy with INDERAL, begun 5-21 days following infarction, was shown to reduce overall mortality up to 39 months, the longest period of follow-up. This was primarily attributable to a reduction in cardiovascular mortality. The protective effect of INDERAL was consistent regardless of age, sex or site of infarction Compared to placebo, total mortality was reduced 39% at 12 months and 26% over an average follow-up period of 25 months. The Norwegian Multicenter Trial in which propranolol was administered at 40 mg q i.d gave overall results which support the findings in the BHAT

Although the clinical trials used either t i.d or q i.d dosing, clinical, pharmacologic and pharmacokinetic data provide a reasonable basis for concluding that b i.d dosing with propranolol should be adequate in the treatment of post-infarction patients

CLINICAL: In the BHAT, patients on INDERAL were prescribed either 180 mg/day (82% of patients) or 240 mg/day (18% of patients). Patients were instructed to take the medication 3 times a day at mealtimes. This dosing schedule would result in an overnight dosing interval of 12 to 14 hours which is similar to the dosing interval for a b.i.d. regimen. In addition, blood samples were drawn at various times and analyzed for propranolol. When the patients were grouped into tertiles based on the blood levels observed and the mortality in the upper and lower tertiles were compared, there was no evidence that blood levels affected mortality.

PHARMACOLOGIC. Studies in normal volunteers have shown that a 90 mg b.i.d regimen maintains beta blockade at, or above, the minimum for 60 mg t.i.d. dosing for 24 hours even though differences occurred at two time intervals. At 10-12 hours after the first dose of the day, t.i d dosing gave more beta blockade than b i.d dosing, at 20-24 hours the trend of the relationship was reversed These relationships were similar in direction to those observed for plasma propranolol levels (see Pharmacokinetic)

PHARMACOKINETIC: A bioavailability study in normal volunteers showed that the blood levels produced by 180 mg/day given b.i d are below those provided by the same daily dosage given t.i.d at 10-12 hours after the first dose of the day but above those of a t i d regimen at 20-24 hours However, the blood levels produced by b.i.d. dosing were always equivalent to or above the minimum for t i.d. dosing throughout the 24 hours. In addition, the mean AUC on the fourth day for the b.i.d. regimen was about 17% greater than for the t.i d regimen (1,194 vs. 1,024 ng/ml•hr).

CONTRAINDICATIONS

INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL

WARNINGS

CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible)

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema) — PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS INDERAL (propranolol hydrochloride) should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL, like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker In one case this resulted after an initial dose of 5 mg propranolol

PRECAUTIONS

General Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug

Pregnancy Pregnancy Category C INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established

ADVERSE REACTIONS

Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular bradycardia; congestive heart failure; intensification of AV block, hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia; visual disturbances; hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

*The appearance of INDERAL tablets is a registered trademark of Ayerst Laboratories.

9371/1184

Ayerst®
AYERST LABORATORIES
New York, N.Y. 10017

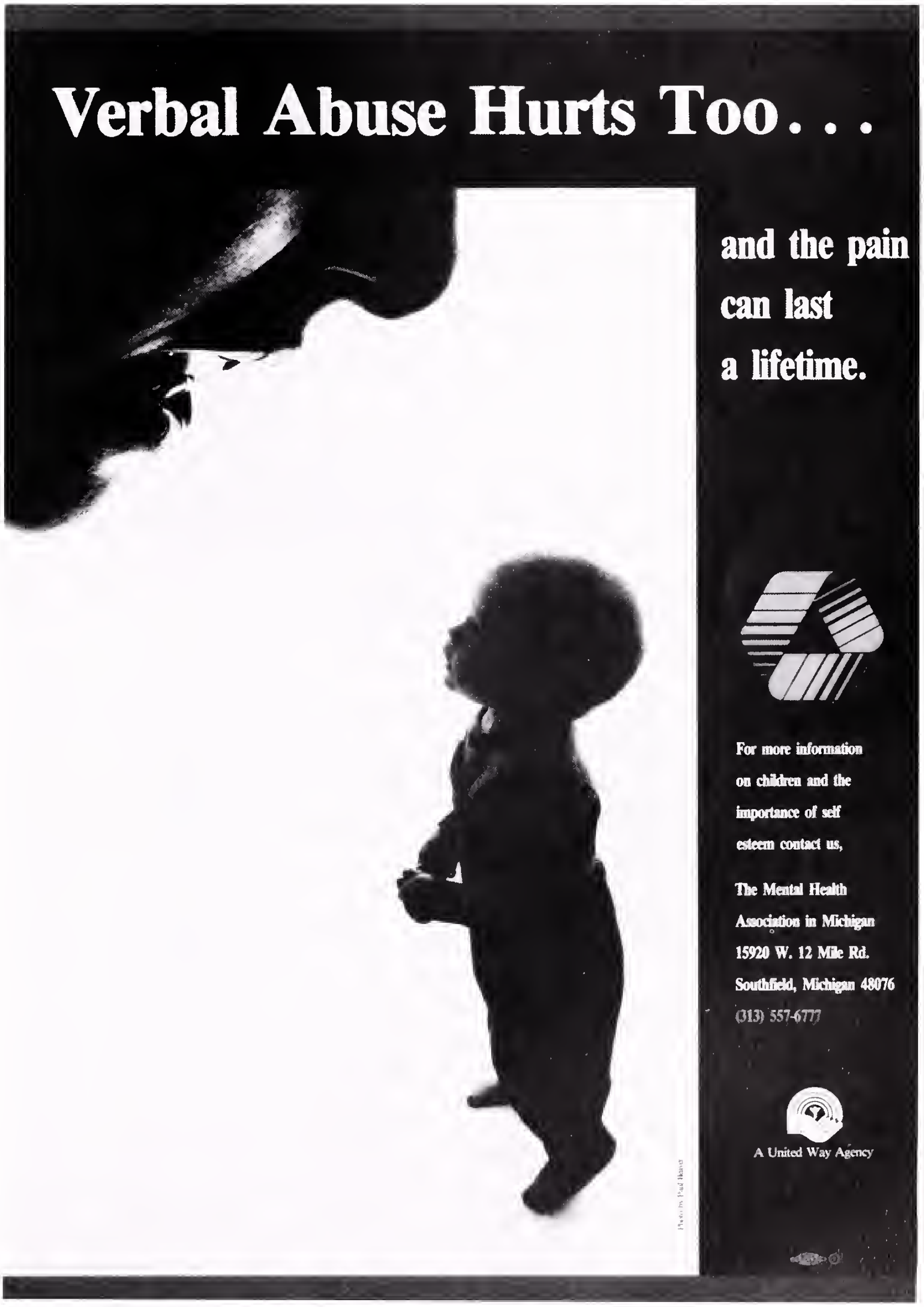
Verbal abuse hurts too!

Broken bones and common colds and rashes too numerous to mention — these are the childhood maladies most often treated by physicians. Concerned parents wince in sympathy to their children's pain, and kiss their bandaged bodies to make them "all better." But many of these same parents will go home and inflict the invisible wounds of verbal abuse, wounds that don't always heal.

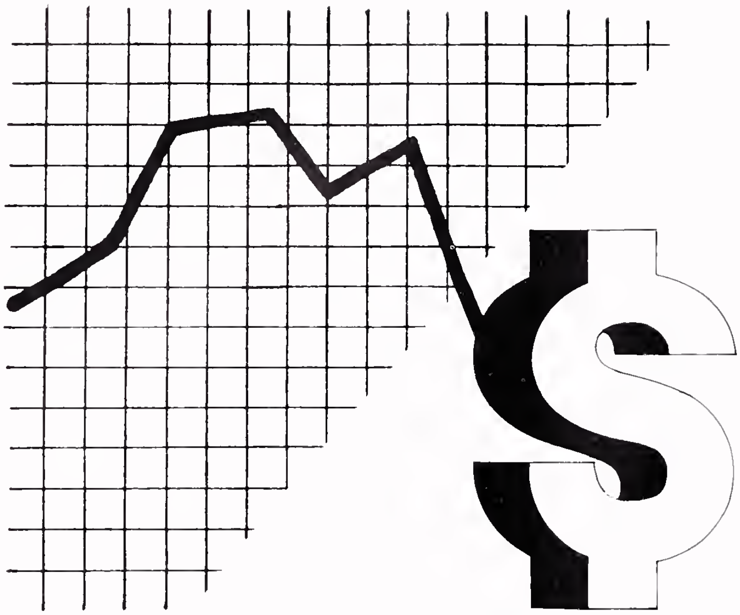
You can remind these parents that verbal abuse hurts, too, with a poster developed by Mental Health Association in Michigan.

The poster makes the point that positive self-esteem is one of the vital ingredients in a mentally and physically healthy life. To build high self-esteem in a child, one must first understand that the child will see himself or herself as other important people (such as parents, teachers, and other care-givers) do. This has been referred to as the "mirror phenomenon", meaning that the child sees and hears a reflection of himself or herself in others.

The poster and other materials are intended to alert and remind adults that they are shaping children with the words they say. If you would like a copy of the "Verbal Abuse" poster (black and white, semi-glossy, 18" x 24"), please send $2.00 to the Mental Health Association in Michigan, 15920 West Twelve Mile Road, Southfield, Michigan 48076, to cover the cost of the poster, plus mailing/handling. If you would like more than one copy, the cost is $1.00 each plus mailing charges (MHAM will bill you or your organization). □


Verbal Abuse Hurts Too . . .
and the pain can last a lifetime.
For more information on children and the importance of self esteem contact us,
The Mental Health Association in Michigan
15920 W. 12 Mile Rd.
Southfield, Michigan 48076
(313) 557-6777
A United Way Agency

By Katharine S. Brown



Advising children on investments

It was one of those lazy, August weekend lunches and the four of us were enjoying a good visit. The topic turned to finances and investing, and our 21-year-old daughter asked, "Mom, how will I know what to do with my investments when you're not around to help?"

Aside from feeling a quiver of mortality, I was delighted. First, as a financial planner, I believe that such topics are far too rare a part of family discussions. Second, and probably most important, the question signaled a "readiness." This was an opportunity not to be missed.

I began by saying that she was absolutely correct in thinking of her investments as a single entity — "my investments" — and not separate parts. Unfortunately, today it is very likely that our investments will become fragmented into all sorts of different categories: stocks, bonds, CDs, money market funds, insurance policies, bank accounts, tax shelters, collectibles, IRAs and more. I believe that all of these pieces taken together comprise one's investment assets.

If you have never done it, I urge you to list these assets in a kind of expanded portfolio. Be sure to include the lot in Florida and the gold coins in the lockbox. Make three groupings: 1) fixed assets like bonds, CDs and annuities; 2) variable assets like stocks, real estate and tax shelters; and 3) cash equivalents like banks accounts and money market funds. Subtotal each grouping and calculate what percentage each is of the total. This process has two important purposes. First, to collect and monitor (it is amazing how often people simply forget or overlook important investment assets). Second, the percentage allocations are critical in the management process because you will want to change the percentages as market conditions and your personal needs indicate.

Market adjustments

Our son asked, "What should these allocation percentages be?" As a general guideline, I suggested one-third fixed and two-thirds variable. However, this general rule should be modified by personal needs for income and liquidity, plus adjustments for the market. "But we don't study the markets every day," he said. "How can we make market adjustments?"

At the risk of being simplistic, I urged him to read the newspaper, especially the front page news. Your clue to when to buy is not just that the market is down, but that the commentary is equally bleak. Of course the contrary also is true: sell when the news is promising. Note that new highs were being reported a few weeks ago amid news about a much stronger economic recovery than had been anticipated.

"Do bonds and CDs work the same way?" Basicially, yes. Interest rates both high and low make the news too. However, I like to simplify fixed asset investing by focusing on one-to-five-year commitments with about the same dollar amount in each year.

Continued on page 604

Ms. Brown is an account executive with Prescott, Ball and Turben, investment banks and brokers, East Lansing. She is consultant to the MSMS Board of Managers on the investment of the MSMS capital and creative reserve fund assets.

DIMENSION III

LOW-COST HEALTH CARE COVERAGE FROM BLUE CROSS AND BLUE SHIELD OF MICHIGAN.

Blue Cross
Blue Shield
of Michigan
SUBSCRIBER NAME
VALUED CUSTOMER
GROUP NO.
94000
EFFECTIVE DATE CURRENT COVERAGE
01 01 83
CONTRACT NUMBER
365 036 429 0 210
SERVICE CODE
12 0 7007 3260
BC PLAN CODE

Now there's a new low-cost health care plan for Michigan State Medical Society members and their employees. It's Dimension III from Blue Cross and Blue Shield of Michigan... a health care plan in which the subscriber shares in the cost of the covered services. Dimension III is a lower cost alternative to the other health care plans presently available to doctors and their employees. Here's how the plan works.

Dimension III for doctors:
Deductible — $1,500 one person
$3,000 family

Dimension III for employees:
Deductible — $250 one person
$500 family

Once the deductible amount has been met, Dimension III pays 80% and the subscriber pays a 20% copayment for covered health care services. When the subscriber has paid $1,000 in copayments, no further copayments are required. Dimension III pays 100% up to $1 million. And when you select one of these plans, you'll get all the benefits that characterize the best health care coverage available:

☐ Hospital care benefits.
☐ Surgery.
☐ Maternity care.
☐ Outpatient care benefits.
☐ Psychiatric care benefits.
☐ The I.D. card that's recognized everywhere.
☐ A minimum amount of paperwork.
☐ A statewide network of Blue Cross and Blue Shield Service Centers to assist you and your employees.
☐ Worldwide coverage for you and your family.

Blue Cross and Blue Shield coverage is the choice of over 5 million Michigan residents. Why not make it your choice, too? For enrollment information, call your local Blue Cross and Blue Shield of Michigan representative.

CAN YOU AFFORD LESS?

Blue Cross
Blue Shield
of Michigan

This creates a kind of "rolling maturity" schedule that tends to smooth out the impact of interest cycles because every year you will have maturing investments able to be reinvested at current rates.

One other thought about bonds: once you have the five-year program underway, consider buying low-coupon (interest rate) issues at "discount" prices. For instance, if interest rates are around 11 percent, you can buy a four and a half percent bond due in 1988 at around 75 cents on the dollar.

The total return, including the 25 cents profit, works out to the same 11 percent, but the profit part is taxed as a capital gain which is 60 percent tax-free. Finally, when selecting bonds be sure to emphasize quality. I generally use bonds rated AA or AAA.

Market funds

"What about cash equivalents? How much should we keep in money market funds?" A base amount equal to three to four months spending, plus any special expenditures known to be coming up, should be kept in a check writing money market fund. The balance of this portion of your investments representing a buying reserve should be held in a money market fund by your broker. This amount will vary up and down like an accordion. It will increase with savings, plus proceeds from maturing bonds and stocks that are sold.

Ideally, the amount and the percentage allocation to cash reserves should be allowed to increase as you sell stocks during a high period in the stock market. Remember that some sales of stock will be suggested simply because your allocation to variable assets will rise significantly above your two-thirds guideline during such a period. Other sales will be made because you determine to reduce your guideline toward 50 percent based on the front page indicator. Reinvestment of the proceeds of a profitable transaction might be delayed until a time when the market was lower.

Then came another good question from our daughter. "How do we know what stocks to buy?" Again she was right—she said *stocks* not stock. Our studies indicate that portfolio risk declines steadily until the number of different holdings reaches 10. Try to diversify into about 10 companies and, if possible, in as many different industries. Then when selecting individual stocks consider these five key elements: 1) quality, 2) growth, 3) dividend payout, 4) debt ratio and 5) value.

Simple research

This is when I nearly lost them. Just in time, I reached for the current issue of *Moody's Handbook of Common Stocks.* (If you don't subscribe, you'll probably find it at your local library.) I pushed aside my plate and opened the book at random. After a moment's study they said, "Oh, here it is! Hershey Foods is investment grade and Hesston is speculative." Then I pointed to the statistics near the bottom: first, earnings per share. I expect earnings at least to keep pace with inflation, and that means having more than doubled in the last 10 years.

Then I pointed to dividend payout percentage. Though I like dividends, I like reinvestment by the company even better. The divident payout should average 40 percent or less. To find the debt ratio, go back up to the top right corner under capitalization. I like low-debt companies and suggest that long-term debt also be less than 40 percent. To discover value, I pointed to the 15-year graph of the stock's price at the top of the page. My son and daughter quickly grasped the crude, but simple visual guide to value as represented by the ups and downs of price action.

I knew they had gotten the message when after looking at a few more companies, our son said, "Boy, was 1974 ever a good time to buy" and our daughter said, "The news must have been terrible then." I left them paging through *Moody's* like a couple of portfolio managers, which of course, like you, they are. ☐

Who needs over a million dollars in professional liability protection?

Very Possibly YOU Do!

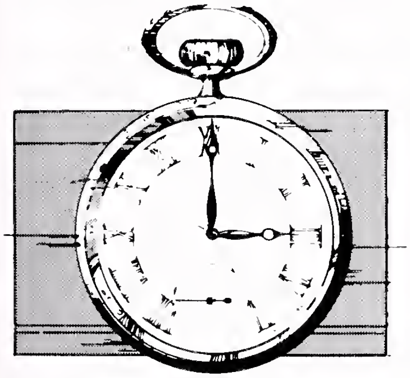
The Michigan lawyers' MILLION DOLLAR CLUB is comprised of attorneys who have won awards over that amount, many from physicians or surgeons who had exercised their very best judgement.

And the jury awards continue to grow.

The Michigan Doctor's Excess Professional Liability Insurance affords...

Protection That Starts When Your Present Policy Stops – And The Jury Keeps Going.

It does not replace your present policy, but it surely supplements it – up to $3 million additional limits.



Now Is The Time To Act!

Changes are effective right now that could be very beneficial to you and your practice. Such as:

- The availability of limits of liability up to **$3,000,000/$3,000,000** excess of $200,000/$600,000 or excess of $1,000,000/$1,000,000;
- A **rate reduction of 10%** for all classes purchasing limits in excess of $200,000/$600,000;
- For P.C.'s, clinics, etc., **discounts up to 50%** for relief or substitute physicians;
- **40-30-30 payment plan** available for annual premiums of $5,000 and above.

For further details about Michigan Doctor's Excess Professional Liability Insurance, please contact HASCO or your insurance agent.

Underwritten by: **PACIFIC EMPLOYERS INSURANCE COMPANY**
Los Angeles, California

Serviced by:
HASCO
P.O. Box 33008
Detroit, Michigan 48232
(313) 567-1955

Whole body

The first whole-body magnetic resonance imaging (MRI) system in Michigan — a $1.5 million device for clinical research is in service at The University of Michigan Medical Center.

Also called nuclear magnetic resonance, this imaging technology, U-M scientists say, has an unmatched ability to reveal the soft tissue of the entire human body. It can locate tumors and tissue damage that even the best computer assisted tomography (CAT) scanners cannot, and does this without X-ray radiation.

Standard X-ray and CAT scans provide detailed images of tissue based on interactions of high energy X-rays and the electrons they enounter in body tissues. Dense bone shows up well, but soft tissues, though very different in chemical composition, may have the same density and thus appear the same shade of gray.

MRI is already considered the best way to diagnose multiple sclerosis, and is potentially useful in the diagnosis and management of cancer, heart disease, strokes and a variety of other conditions.

Mentally retarded

Not since 1922 has the number of mentally retarded people in state centers been as low as it was at the beginning of the 1984 state fiscal year.

State Mental Health Director C. Patrick Babcock reported today that Michigan had only 2,600 people living in state developmental centers at the start of the year. He noted that Michigan's population in the 1920s was only 3.7 million, compared to 9.3 million today.

One year ago, there were nearly 3,000 persons in state centers. These figures are in sharp contrast to the mid-1960s when population at the centers peaked at nearly 13,000.

Michigan's efforts to reduce the number of persons in state centers have been underway for more than a decade. The movement is based on four critical factors:

- Mental retardation authorities in Michigan and throughout the U.S. have documented that most developmentally disabled persons progress most rapidly when care is provided in a small, home-like setting.
- Legal challenges to institutional care, at both the state and federal level, have established the principle that services should be provided in the least restrictive environment.
- Passage of Michigan's mandatory special education act, a decade ago, assured the availability of appropriate, community-based training programs for all handicapped citizens.
- Costs for 24-hour facility care have soared during the past decade, reflecting both unprecedented inflationary pressures and requirements for higher standards of care.

Babcock said the continued development of community residential programs, and the decline in the number of persons in state centers was good news for residents of state centers and their families, and for state taxpayers.

Toxic topicals

Topical ocular medications, including the so-called diagnostic pharmaceutical agents or DPAs, are drugs capable of causing serious ocular and systemic effects report two Michigan researchers in a recent paper. Their use should be restricted to persons who have the training to recognize and manage potentially serious and sometimes fatal side effects, they say. Non-physician drug use is not in the public's best interest.

Philip C. Hessburg, MD, Grosse Pointe Park, and Greg Montpetit, Wayne State University, reviewed the reactions to topical ocular medications which have been reported by physicians to the National Registry of Drug Induced Ocular Side Effects. They compared them in some respects with reactions to the same group of drugs reported by optometrists to the Wisconsin Attorney General's office.

The drugs under discussion for use as diagnostic pharmaceutical agents all have local effects on the eye. All of these drugs also soak into the blood stream and, therefore, can have minor or serious systemic (or body) effects. Reactions to these drugs are infrequent (but not rare) in terms of the incidence of fatalities related to their use. The exact incidence of such reactions is unknown because minor side effects (some of which can be confused with serious problems) as well as very serious side effects often go unreported to agencies such as the National Registry of Drug Induced Ocular Side Effects.

Some evidence exists to suggest that the non-physician frequently does not recognize the reactions caused by topical ocular drugs especially if these reactions are outside the body system emphasized in the physician's area of academic study. If the non-physician fails to recognize the side effect of the drug used, it is impossible for him to refer the patient for help since he does not know he has a problem until the opportunity for successful management has passed.

The rate of overall referral of four percent by optometrists to other medical specialties is disconcerting. Every study of pathological incidence of which we are aware indicates that the combined numbers of persons who have strabismus, glaucoma, cataract, senile macular degeneration and other ocular diseases (which are treatable when recognized early enough) far exceeds four percent. Their cumulative incidence after age 50 years is probably greater than 30 percent. If that is true, one wonders why optometrists in a state such as Wisconsin (which already has DPA legislation) refer only four percent of these people to medical doctors. Two conclusions are possible. Wisconsin optometrists either do not recognize pathology or do not refer that pathology which they do recognize. It becomes a specious argument to advocate legislation which will allow DPA use by non-physicians in order to improve referral rates since, in the state of Wisconsin, optometrists (who already have enabling legislation) still do not refer patients appropriately.

Many of the reactions caused by topical ocular pharmaceuticals are potentially serious. These drugs have the potential for lethal reactions. They have caused such reactions in the past, can and will cause fatalities in the future. Even the potential of such reactions should not occur in the offices of practitioners ill-equipped by training to diagnose and manage such drug reactions.

U-M Clinical Research Center

The University of Michigan Hospitals' Clinical Research Center (CRC) has been awarded a five-year grant renewal of $13 million. The renewal, which begins in December 1985, represents a 15 percent increase in funding.

The U-M's center is one of 75 general clinical research centers funded by the Division of Research Resources at the National Institutes of Health. NIH has supported the center since 1962.

The CRC is a self-contained 18-bed unit on the fourth floor of Main Hospital. Clinical research studies are carried out by U-M faculty with patient volunteers. The center includes laboratories, administrative offices, an outpatient area, a computer facility and a kitchen where special diets are prepared for patient volunteers.

More than 80 research projects are under way at the center by more than 50 faculty, according to Irving Fox, MD, center director. The studies involve both regular volunteers and patients with a variety of diseases for which treatment is being sought. The center sees between 600 to 800 adult and pediatric patients each year from around the world.

Impaired healing

There is a direct association between cigarette smoking and the ability to heal following a facelift, according to Dr. Thomas D. Rees, a plastic surgeon affiliated with the Manhattan Eye, Ear, and Throat Hospital. Patients who smoke have twelve and a half times the chance of developing skin slough than patients who do not smoke, he indicated. Skin slough results in delayed healing and more noticeable scar formation.

Doctor Rees reviewed the records of 1186 consecutive patients who had undergone facelift surgery from 1975 through 1981. One-hundred twenty-one patients had evidence of skin slough, and 80 percent admitted to smoking more than one pack of cigarettes a day.

Because nicotine constricts blood vessels, its impact on healing is compounded in surgery where the blood supply to facial skin is already temporarily reduced.

"Heavy smokers can reasonably be denied elective aesthetic surgery unless they stop," Doctor Rees concludes. "Perhaps a suitable admonition to the smoking patient would be 'Warning — smoking can be hazardous to your facelift.'"

Reye's Syndrome

No additional cases of Reye's Syndrome were reported in Michigan children since July 16, the date of the last update memo. A total of 22 cases have been reported since October 1, 1983.

In late October, after the close of the 1983-84 RS year, the Department of Public Health will be contacting RS Treatment Center Reporting Coordinators from hospitals that have reported RS cases to make arrangements for a routine annual medical record review of the past year's cases. The purpose of this review is to obtain additional detail regarding laboratory results that came in after the initial report, apply uni-

Continued on page 608

Michigan Conference on Maternal and Perinatal Health

March 20-21, 1985
Hyatt Regency Dearborn

For details: Michigan State Medical Society, P.O. Box 950, East Lansing, MI 48823 (517) 337-1351

Do you know

a physician with problems of alcoholism, drug abuse, emotional illness or other difficulties which interfere with his or her ability to practice medicine?

If so, please contact your MSMS Program to Assist Impaired Physicians through Katie Brewbaker at MSMS headquarters, (517) 337-1351.

NEWSFRONTS/Continued

form staging criteria, etc., so that we have a uniform data base upon which to base epidemiologic analyses.

Note: The case control-study will continue through the 1984-85 RS sesason. Treatment Center Reporting Coordinators are urged to continue to report cases to DSS by phone promptly upon diagnosis.

Michigan voluntary hospitals organize

Henry Ford Hospital, Detroit; Butterworth Hospital, Grand Rapids, and William Beaumont Hospital, Troy are among 16 non-profit Michigan hospitals that have formed a new corporation called VHA of Michigan, with headquarters in Lansing.

The hospital network, whose members currently represent 6,100 beds and 25,000 employees, is part of the nationwide Voluntary Hospitals of American (VHA). The group was formed in 1977 to strengthen the voluntary hospital sector and to improve its competitive position by providing systems' advantages while maintaining local autonomy and control.

The purpose of the national and state VHA is to give member institutions a competitive edge within their markets through such services as bulk purchasing; capital financing; management services; productivity analysis; a communications network; and other programs and services, all while retaining local community control.

Through consolidation strategies and joint business ventures, VHA of Michigan is structured to reduce hospital costs and respond to community needs with the ultimate goal of providing improved patient care.

Other hospitals in the Michigan VHA are:

— Bay Medical Center, Bay City;
— Central Michigan Community Hospital, Mt. Pleasant;
— Community Hospital Association, Battle Creek;
— Cottage Health Services, Grosse Pointe;
— McPherson Community Health Center, Howell;
— Memorial Medical Center of West Michigan, Ludington;
— Northern Michigan Hospitals, Inc., Petoskey;
— Oakwood Hospital, Dearborn;
— Port Huron Hospital, Port Huron;
— Saginaw General Hospital, Saginaw;
— Southwestern Michigan Health Care Association, St. Joseph;
— St. Clair Health Corporation, Detroit;
— United Memorial Hospital, Greenville.

The governing body is composed of the chief executives of each member hospital. Donald Walchenbach, president of Butterworth Hospital, is chairman of the Board of the Michigan VHA.

Hypertension booklet

Physicians have available a new "Handbook for the Management of Hypertension." The material in the handbook is a synthesis of a slide/tape program "Controlling High Blood Pressure in Michigan: A Challenge for the Eighties," in an easy to use format. A section of the book is a considerable expansion of the blood pressure measurement material in the module, which has been included as reference, because some of it, particularly the equipment maintenance and purchase section, are difficult to find in reference material.

Additional copies of this handbook are available for purchase through Media Library, University of Michigan Medical Center, R4440 Kresge I, Box 056, Ann Arbor, MI 48109-0010.

The handbook was produced by the University of Michigan Department of Postgraduate Medicine and Health Professions Education under a National Institutes of Health contract with the Michigan Department of Public Health.

Competence counts

Hurley Medical Center photo

In selecting a doctor, 74 percent of Americans consider competence, not cost.

Competent doctors remain the key to health. But competence isn't immunity to litigation.

Consider our competence – and our professional liability protection and strong-defense philosophy.

We defend you against non-meritorious claims. We won't settle a claim without your approval or merely to cut our defense cost.

PICOM
Physicians Insurance Company Of Michigan
4277 Okemos Rd., Box 1000
Okemos, Michigan 48864
(517) 349-6500
(313) 557-4845
1-800-292-1036

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

David N. Alperstein — PS
14800 W. McNichols
Detroit 48235

Julian A. Alvarez, MD — AN
468 Cadieux
Grosse Pte. 48230

Marvin D. Anderson, MD — IM/NTR
2428 Galpin
Royal Oak 48073

Jack Belen, MD — PM
15950 Jeanette
Southfield 48075

Robert S. Bloch, MD — GS
27300 Franklin #214
Southfield 48034

Kingkhan Boriboon, MD — PD
3815 Pelham Rd.
Dearborn 48124

Chaim M. Brickman, MD — IM/A
25960 Raine
Oak Park 48237

Joseph R. Buck (Student)
25402 Billette Dr.
Warren 48091

T. Jann Calson-Sorey, MD — PD
2799 W. Grand Blvd.
Detroit 48202

Mariann M. Channell, MD — OPH
57 Hawthorne Rd.
Grosse Pte. 48236

Christopher C. Chaput, MD — AN
32675 Bingham Rd.
Birmingham 48010

Ginger L. Dattilo, MD — IM
803 Fountain, N.E.
Grand Rapids 49503

Rajendra B. Desai, MD — PD/NPM
6767 W. Outer Dr.
Detroit 48235

Jerry Drake, MD — DR
18242 Snow Rd.
Dearborn 48124

Vilma Drelichman, MD — ID/IM
3495 Rochester Rd.
Troy 48084

Andrew I. Dzul, MD — OTO
19501 E. Eight Mile Rd.
St. Clair Shores 48080

Bruce M. Eisenberg, MD — IM
17550 W. 12 Mile Rd.
Southfield 48076

Robert A. Fishman, MD — OTO
19501 E. Eight Mile Rd.
St. Clair Shores 48080

Robert J. France, MD — IM
22151 Moross Rd.
Detroit 48236

James D. Gay, MD — PTH
100 Michigan St., NE
Grand Rapids 49503

Mark A. Goosmann, MD — EM
100 Michigan Ave., NE
Grand Rapids 49503

Evan J. Griffiths, MD — OBG
4114 Grandview Rd.
Royal Oak 48073

Vashna Gupta, MD — IM
1660 Kingsway Ct.
Trenton 48183

L'Tanya Haith, MD — PD
1971 Elmwood Park Dr. #304
Detroit 48207

Sue J. Han, MD — RT
6767 W. Outer Dr.
Detroit 48235

Continued on page 612

LABORATORY OF CLINICAL MEDICINE
MID-MICHIGAN REFERENCE LABORATORY, II, Inc.
(517) 372-8180

1322 E. Michigan Ave.
Suite 211
Lansing, Michigan 48912

930 E. Mt. Hope Ave.
Lansing, Michigan 48910

2909 E. Grand River Ave.
Suite 104
Lansing, Michigan 48912

W. E. Maldonado, M.D.
Director

Robert B. Foy, Ph.D.
Chief Executive Officer

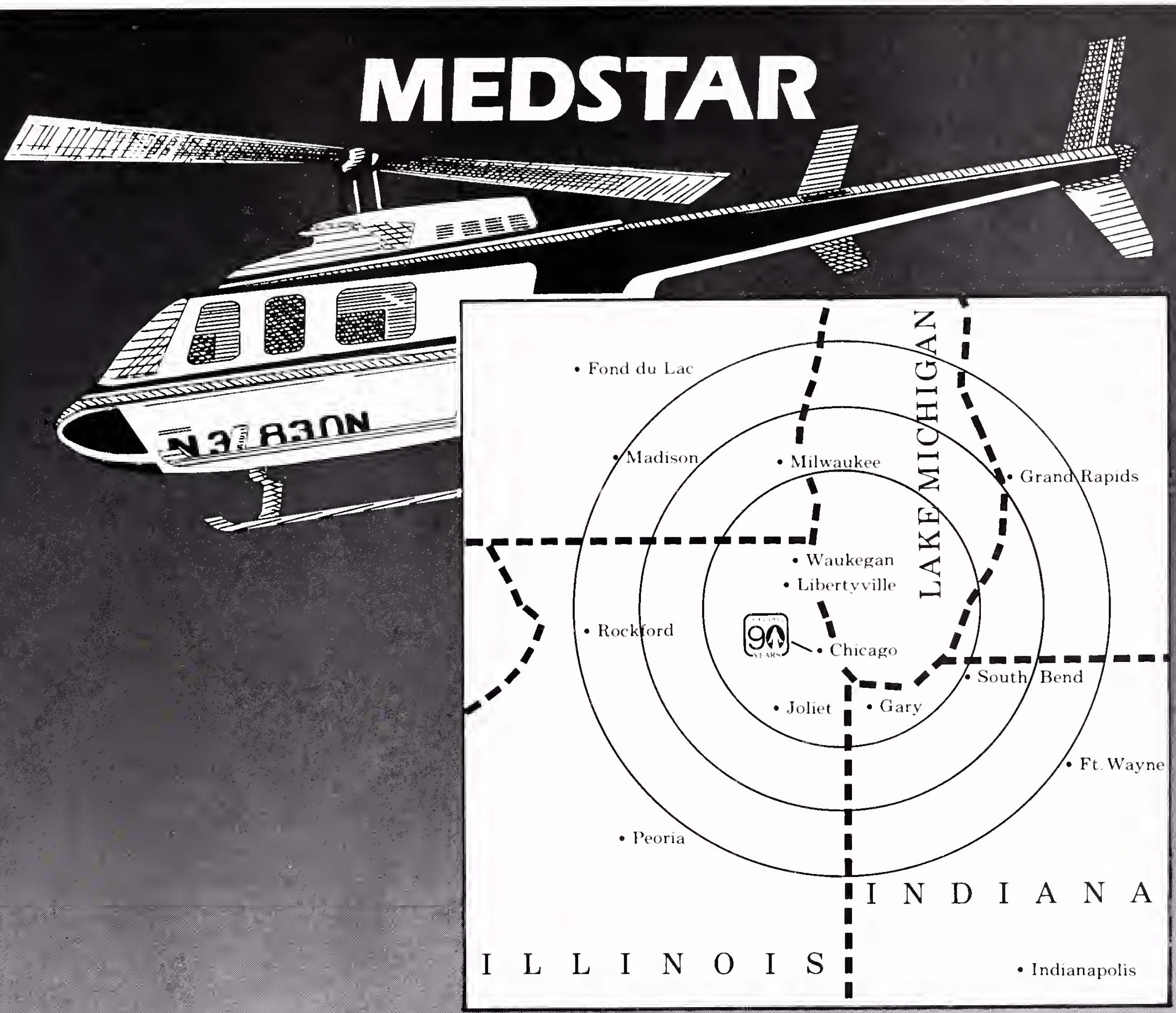
Ann E. Chernys, M.D.
John W. Dyke, Ph.D.
Dennis E. Freer, Ph.D.
John J. Gillespie, M.D.
Ronald N. Horowitz, M.D.
John R. Kateley, Ph.D.

LABORATORY OF CLINICAL MEDICINE
MID MICHIGAN REFERENCE LABORATORY

John J. Lyday, M.D.
Joseph R. Melvin, Ph.D.
Sandra K. Shirley, M.D.
Laurence R. Simson, Jr., M.D.
Susan M. Strate, M.D.
Irene K. Trombley, M.D.

REFERENCE LABORATORY FOR SPECIALIZED PROCEDURES
Specimen Pickup and Delivery of Test Results Daily
House calls are available upon Physician's request
Assignment is accepted from Medicare, Medicaid, Blue Shield and all other insurance carriers.

MEDSTAR



N37830N
Fond du Lac
Madison
Milwaukee
Grand Rapids
LAKE MICHIGAN
Waukegan
Libertyville
Rockford
90 YEARS
Chicago
South Bend
Joliet
Gary
Ft. Wayne
Peoria
INDIANA
ILLINOIS
Indianapolis

WHEN LIVES DEPEND ON MINUTES, YOU CAN DEPEND ON MEDSTAR.

MedStar is Saint Mary Of Nazareth Hospital Center's emergency helicopter transport system. It can cut travel time as much as three fold, and offers advanced life support systems, specially trained crews, and immediate accessibility to and from facilities within 125 miles of Chicago.

But that's only the beginning of what MedStar means to every medical facility within our service area.

It's also your patients' lifeline to a unique partnership between physicians and health care providers — a partnership that taps the entire spectrum of tertiary care services available within our radius. MedStar is first and foremost dedicated to continuing the care you've initiated, and returning the patient to your care as soon as possible.

It's the kind of service you'd expect from Saint Mary's. Our 490-bed facility is one of Chicago's major training centers for critical care specialists. Our own staff of specialists render hyperacute patient care services ranging from limb reattachment and microsurgery to open heart and emergency neurosurgery.

So when you depend on MedStar, you can depend on Saint Mary's. That's what partners are for. To help.

For More Information, Call Our Program Director at (312) 770-3273.

1897 1987 90 YEARS

Saint Mary of Nazareth
Hospital Center
2233 W. Division Street • Chicago, IL 60622

NEW MEMBERS/Continued

Stephen D. Hershey, MD — GS
9130 Devonshire
Detroit 48224

Jagdish M. Hodarkar, MD — IM
4644 Colonial Lane
Trenton 48183

Kim J. Horowitz, MD — FP
17056 Sprenger
East Detroit 48021

Curtis L. Hunt, MD — IM
125 E. 14 Mile Rd. #8
Birmingham 48009

Roy A. Jacobstein, MD — PD
502 Rock Creek Dr.
Ann Arbor 48104

Brandi M. Jenson, MD — PD
11000 Burlington #406
Southgate 48195

Kiran Kinra, MD — IM
902 E. Hamilton Ave.
Flint 48550

Steven E. Koester, MD — FP
5120 McGuiness
Dexter 48130

Linda J. Kole, MD — IM
6777 W. Maple Rd.
West Bloomfield 48033

Patricia A. Kolewich, MD — ORS
2231 Placid Way
Ann Arbor 48105

Melvyn T. Korobkin, MD — DR
6767 W. Outer Dr.
Detroit 48235

Warren L. Kupin, MD — IM
1350 W. Bethune #705
Detroit 48202

Patty J. Kulpa, MD — OBG
1425 Michigan St., NE
Grand Rapids 49503

Fred S. Lamb, MD — PD
Henry Ford Hospital
Detroit 48202

"I hate to wake him — he had a rather restless night."

Donald J. Lang, MD — OTO
1213 South Drive
Mt. Pleasant 48858

Horacio G. Lardo, MD — AN
11800 12 Mile Rd.
Warren 48093

Scott D. Larson, MD — EM/IM
2617 Winchell Ave.
Kalamazoo 49008

Robert J. Levy, MD — N
2350 Washtenaw
Ann Arbor 48104

Charles G. Lischer, MD — ORS
820 Lester Ave.
St. Joseph 49085

J. March Maquilan, MD — TS/CDS
1717 Shaffer #213
Kalamazoo 49002

Kenneth D. McClatchey, MD — CLP
U/M Dept. of Path. Box 45
M5230 Med. Science I Bldg.
Ann Arbor 48104

Allan D. Mills, MD — GS
28 Jefferson
Pontiac 48058

Robert H. Nettleman, MD — FP
230 W. Oak St.
Fremont 49412

James M. Nosal, MD — FP
2303-9 E. Jolly Rd.
Lansing 48910

Harivallabh Pandya, MD — IM
19440 Van Dyke
Detroit 48234

Nathan E. Pearson, Jr., MD — IM
20905 Greenfield #300
Southfield 48075

Ruben Perez-Perez, MD — FP
18242 Snow Rd.
Dearborn 48124

Perry G. Pernicano, MD — DR
4008 W. 13 Mile Rd. #40
Royal Oak 48072

Kevin L. Piggott (Student)
15205 Kinloch
Redford Twp. 48239

Carol Prince, MD — EM
19206 Santa Rosa Dr.
Detroit 48221

Dennis A. Rasbach, MD — GS
820 Lester Ave.
St. Joseph 49085

Richard Reid, MD — GYN
26206 W. 12 Mile Rd. #106
Southfield 48034

Dwight R. Reynolds, MD — PD
314 S. Brown St.
Mt. Pleasant 48858

Martin C. Robson, MD — GS/PS
4201 St. Antoine #6-D
Detroit 48201

Michael L. Ross, MD — DR
6767 W. Outer Dr.
Detroit 48235

Maria Row-Gorosh, MD — FP
12927 Victoria
Huntington Woods 48070

Michael J. Schnitzer, MD — PD
1841 Chester #32
Royal Oak 48073

A.C. Shringeri, MD — PD/A
P.O. Box 885
Bloomfield Hills 48013

Michael D. Singer, MD — AN
1060 W. Norton
Muskegon 49441

David C. Slawson, MD — FP
220 Burdette St.
St. Ignace 49781

Pachagiri L. Suresh, MD — DR/NM
48671 I-94 Serv. Dr. #110
Belleville 48111

Ghalib Y. Talia, MD — CRS
909 Woodward #111
Pontiac 48053

Steven J. Van Doornik, MD — N
285 James St.
Holland 49423

James B. Veldkamp, MD — IM
2140 Lake Michigan Dr., NW
Grand Rapids 49504

Rudy J. Vervaeka, MD — IM/EM
23218 Edsel Ford Ct.
St. Clair Shores 48080

David E. Vincent, MD — P/CHP
31275 Northwestern Hwy. #130
Farmington 48050

Bryan D. Visser, MD — PM&R
363 Bronson Medical Center
Kalamazoo 49007

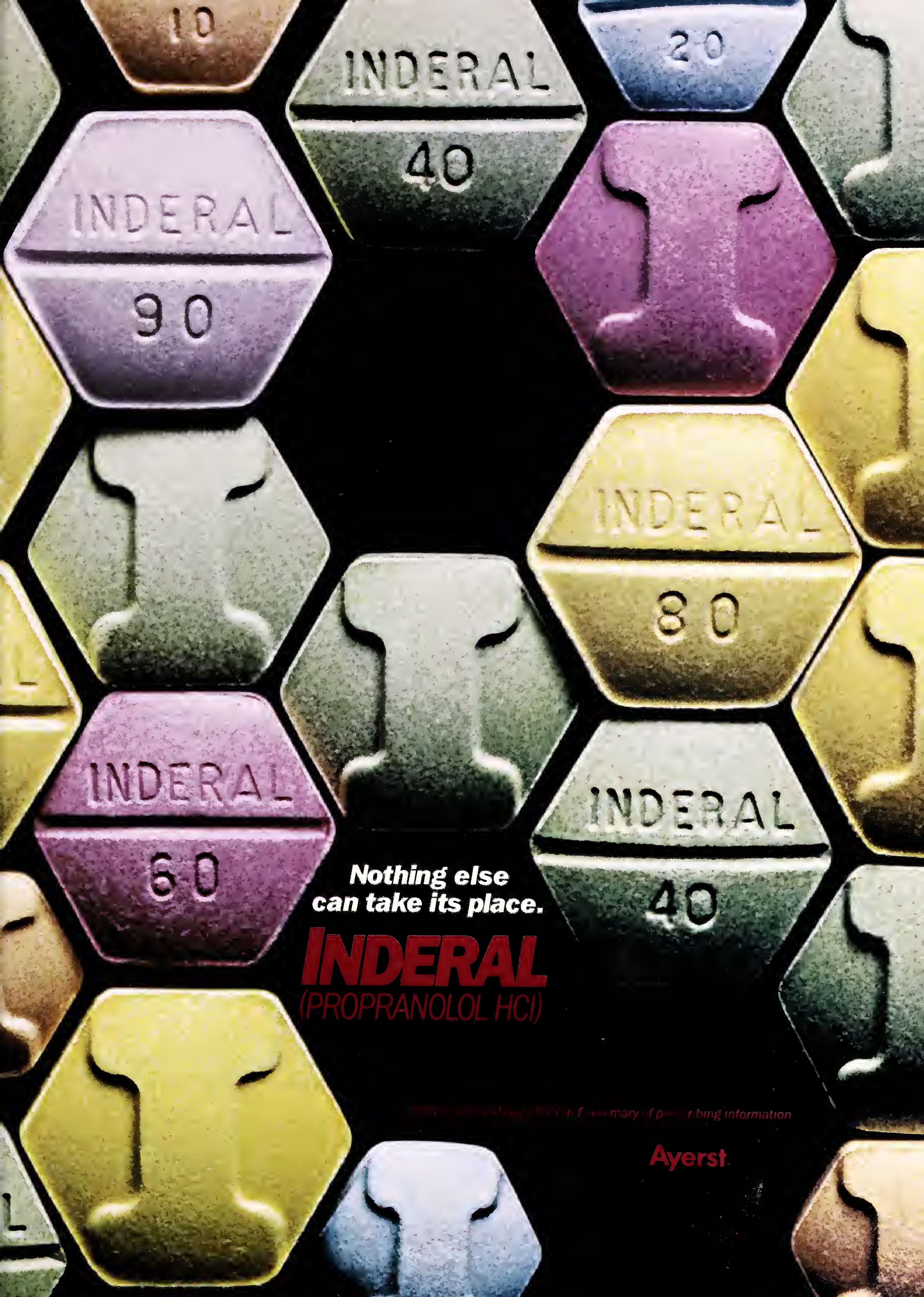
Patrick A. Wegman, MD — D/IM
1980 Briarcliff Blvd.
Owosso 48867

Saul I. Weingarden, MD — PM
16050 Sherfield
Southfield 48075

Christina L. Winder, MD — FP
5752 Guilford
Detroit 48224

Steven T. Yedlin, MD — PDS/GS
3901 Beaubien
Detroit 48201

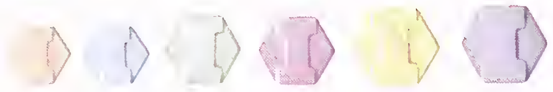
Robert A. Young, MD — ORS
3570 Frederick Dr.
Ann Arbor 48105


10
INDERAL
40
20
INDERAL
90
INDERAL
80
INDERAL
60
INDERAL
40
Nothing else
can take its place.
INDERAL
(PROPRANOLOL HCl)
[illegible] summary of prescribing information
Ayerst

Nothing else can take its place.

INDERAL®

(PROPRANOLOL HCl)



BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

INDERAL® (propranolol hydrochloride) Tablets

CLINICAL PHARMACOLOGY

The Beta-Blocker Heart Attack Trial (BHAT) was a National Heart, Lung and Blood Institute-sponsored multicenter, randomized, double-blind placebo-controlled trial conducted in 31 U.S. centers (plus one in Canada) in 3,837 persons without history of severe congestive heart failure or presence of recent heart failure; certain conduction defects; angina since infarction, who had survived the acute phase of myocardial infarction. Propranolol was administered at either 60 or 80 mg t.i.d. based on blood levels achieved during an initial trial of 40 mg t.i.d. Therapy with INDERAL, begun 5-21 days following infarction, was shown to reduce overall mortality up to 39 months, the longest period of follow-up. This was primarily attributable to a reduction in cardiovascular mortality. The protective effect of INDERAL was consistent regardless of age, sex or site of infarction. Compared to placebo, total mortality was reduced 39% at 12 months and 26% over an average follow-up period of 25 months. The Norwegian Multicenter Trial in which propranolol was administered at 40 mg q.i.d. gave overall results which support the findings in the BHAT.

Although the clinical trials used either t.i.d. or q.i.d. dosing, clinical, pharmacologic and pharmacokinetic data provide a reasonable basis for concluding that b.i.d. dosing with propranolol should be adequate in the treatment of post-infarction patients.

CLINICAL. In the BHAT, patients on INDERAL were prescribed either 180 mg/day (82% of patients) or 240 mg/day (18% of patients). Patients were instructed to take the medication 3 times a day at mealtimes. This dosing schedule would result in an overnight dosing interval of 12 to 14 hours which is similar to the dosing interval for a b.i.d. regimen. In addition, blood samples were drawn at various times and analyzed for propranolol. When the patients were grouped into tertiles based on the blood levels observed and the mortality in the upper and lower tertiles were compared, there was no evidence that blood levels affected mortality.

PHARMACOLOGIC. Studies in normal volunteers have shown that a 90 mg b.i.d. regimen maintains beta blockade at, or above, the minimum for 60 mg t.i.d. dosing for 24 hours even though differences occurred at two time intervals. At 10-12 hours after the first dose of the day, t.i.d. dosing gave more beta blockade than b.i.d. dosing; at 20-24 hours the trend of the relationship was reversed. These relationships were similar in direction to those observed for plasma propranolol levels (see Pharmacokinetics).

PHARMACOKINETIC: A bioavailability study in normal volunteers showed that the blood levels produced by 180 mg/day given b.i.d. are below those provided by the same daily dosage given t.i.d. at 10-12 hours after the first dose of the day but above those of a t.i.d. regimen at 20-24 hours. However, the blood levels produced by b.i.d. dosing were always equivalent to or above the minimum for t.i.d. dosing throughout the 24 hours. In addition, the mean AUC on the fourth day for the b.i.d. regimen was about 17% greater than for the t.i.d. regimen (1,194 vs. 1,024 ng/ml• hr).

CONTRAINDICATIONS

INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS

CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

> IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL (propranolol hydrochloride) should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL, like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS

General. Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy. Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances; hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

*The appearance of INDERAL tablets is a registered trademark of Ayerst Laboratories.

8965/284

Ayerst®
AYERST LABORATORIES
New York, N.Y. 10017

Maternal Health Desk Reference Card No. 28

(Sponsored and Prepared by the Committee on Maternal and Perinatal Health, Michigan State Medical Society)

Use of Prophylactic Rho (D) Immune Globulin (RhIG)

Recommendations of the Maternal and Perinatal Health Committee of the Michigan State Medical Society.

I. **Rho (D) Immune Globulin should be given:**

A. Postpartum (ideally within 72 hours or as soon as indication is recognized, up to 28 days postpartum) to all women who are Rho (D) negative (whether Du positive or Du negative) who are not Rho (D) isoimmunized, and deliver an Rho (D) or Du positive infant. The recommendation to give RhIG to all Rho (D) negative postpartum patients irrespective of their Du status is based upon two findings:

1. A very small percentage of the population is genetically Du positive and Rho (D) negative (0.2%).
2. When testing is done late in pregnancy or postpartum, the Du negative patient might type as Du positive if she is carrying an Rho (D) positive fetus.

If a shift is noted from Du negative early in pregnancy to Du positive postpartum, it might indicate a significant fetal-maternal bleed requiring more than the usual dose of RhIG. Further studies to quantitate the amount of fetal blood in the maternal circulation would be appropriate.

B. To all pregnant or recently pregnant women who are Rho (D) negative and unsensitized who undergo:

1. An abortion, either induced or spontaneous (the Rh antigen does not appear until 6 weeks after conception).
2. An ectopic pregnancy.
3. Second or third trimester amniocentesis.
4. Chorionic-villi sampling.
5. External breech conversion.

C. To all pregnant Rho (D) negative women who are unsensitized and have reached the 28th week of pregnancy:

1. Approximately 1-2% of Rho (D) negative women become sensitized during the antepartum period, primarily the third trimester. RhIG given at 28-32 weeks gestation can reduce Rho (D) isoimmunization to a minimum. The latest cost estimates indicate that this recommendation is cost effective.

   An exception may be made if a reliable blood type is available indicating the *father* of the baby is also Rho (D) negative.

2. RhIG should be given postpartum to all eligible patients despite finding a weakly positive antibody screen in the mother and/or a positive direct Coombs in the infant. Antepartum prophylaxis with RhIG may provide sufficient passively acquired antibody to make these tests positive. The postpartum injection of RhIG should not be withheld unless there is unequivocal proof that the infant has been actively immunized.
3. The usual postpartum dose may be withheld if delivery occurs within 21 days of the last injection with RhIG. Consideration should be given to more frequent RhIG injections, e.g. every four weeks, in patients who have recurrent problems such as antepartum hemorrhage.

II. **Dosage of RhIG:**

The recommendation is to give 300 ug. of RhIG for all indications except when a higher dose may be needed (e.g. significant fetal-maternal hemorrhage or transfusion of an Rho (D) negative unsensitized patient with Rho (D) positive blood). The lower dose 50 ug. vial of RhIG may be used postabortively prior to the 13th week of pregnancy. Antepartum prophylactic RhIG does not require a pre-injection cross match.

III. **Non-Obstetric indications following the use of blood or blood products:**

A. Transfusion of Rho (D) positive blood into an Rho (D) negative woman. Under these circumstances, multiple doses of RhIG can be given to prevent Rho sensitization. The accepted RhIG dosage is 20 ug/ml. of whole blood transfused, administered in divided doses at 12 hour intervals within the usual 72 hour period.

B. Infusions of Other Blood Products:

Extremely small amounts of Rho (D) positive cells (0.03 ml) may cause a primary immunization. Since it is difficult to obtain blood products completely free of Rho (D) positive cell contamination, RhIG should be given following the administration of any blood products to an unsensitized RhD negative female.

This reference card was written for the Maternal and Perinatal Health Committee by Lloyd A. Kammeraad, M.D., Grand Rapids, Michigan and accepted September, 1984. References are available from the author.

The above Desk Reference Card desecribes methods and techniques of clinical practice that are currently acceptable and used by recognized authorities. However, it does not represent official policy or recommendations of the Michigan State Medical Society and its publication should not be construed as excluding other acceptable methods of handling similar problems.

CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, (517) 337-1351.

Date: November 14, Alcoholism. Location: St. John Hospital. **Sponsor:** CME Committee of St. John Hospital. **For:** Interested physicians. **Cost:** $90.00. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road, Detroit 48236 (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

November 18, Eighth Annual Pediatrics Seminar. Location: Kellogg Center for Continuing Education. **Sponsor:** Michigan State University College of Osteopathic Medicine's Department of Pediatrics. **Contact:** Sandy Kilbourn, A306 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 6½ hours of Category I Credit.

Date: December 3-7, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Education, East Lansing. **Sponsor:** MSU Colleges of Osteopathic and Human Medicine and North American Academy of Manipulative Medicine. **Contact:** Sandy Kilbourn, A306 E. Fee, MSU-COM, East Lansing 48824 (517) 353-9714. **Approved for:** 40 hours of Category I Credit.

Date: December 7, Care of the Burned Patient. Location: Towsley Center. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, University of Michigan Medical School, Towsley Center, Box 057, Ann Arbor 48109 (313) 763-1400. **Approved for:** 7 hours of Category I Credit.

Date: December 7-8, Practical Otolaryngology Conference for Primary Care Practices. Location: Grace Hospital, Detroit. **Sponsor:** Wayne State University. **Contact:** WSU Continuing Education Office, (313) 927-3534. **Approved for:** 10 hours of Category I Credit.

Date: December 8, Michigan Society of Pathologists December Seminar. Location: Rackham Auditorium, Ann Arbor. **Sponsor:** Michigan Society of Pathologists. **Contact:** Kenneth McClatchey, Department of Pathology, University of Michigan Hospital, Ann Arbor, 48109. **Approved for:** 3 hours of Category I Credit.

Date: January 12, 1985, Primary Care Medicine: An Exciting Frontier Revisited. Location: Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit, 48202 (313) 876-3073. **Approved for:** 16 hours of Category I Credit.

Date: January 27-February 1, 1985, Schuss Mountain Conference on Emergencies in Medicine. Location: Schuss Mountain, Mancelona. **Sponsor** Wayne State University, Department of Surgery, and Michigan Committee on Trauma. **Contact:** Theresa Sokol, Wayne State University Department of Surgery, 6-C UHC, 4201 St. Antoine, Detroit, 48201 (313) 577-5009. **Approved for:** 25 hours of Category I Credit.

Date: February 4-6, 1985, Hemodynamic Monitoring VII. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, Ann Arbor 48109 (313) 763-1400. **Approved for:** 14.5 hours of Category I Credit.

Date: February 27, 1985, Cardiology-Update. Location: St. John Hospital. **Sponsor:** CME Committee of St. John Hospital. **For:** Interested physicians. **Cost:** $90.00. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road, Detroit 48236 (313) 343-3877 **Approved** for: 8 hours of Category I Credit.

Date: April 10, 1985, Primary Care Medicine: An Exciting Frontier Revisited. Location: Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313) 876-3073. **Approved for:** 16 hours of Category I Credit.

Date: April 25-25, 1985, 14th Annual Wayne State University Critical Care Symposium. Location: Northfield Hilton, Troy. **Sponsors:** Wayne State University, Department of Surgery, Michigan Committee on Trauma, and Michigan Society of Critical Care Medicine. **Contact:** Theresa Sokol, Wayne State University, Department of Surgery, 6-C UHC, 4201 St. Antoine, Detroit 48201 (313) 557-5009. **Approved for:** 12 hours of Category I Credit.

Continued on page 618

Professional
INSTALLMENT LOANS

$15,000
TO
$90,000

Decision In
24 to 48 Hours!

**Same-Day Answer
to Applications
Received By Express Mail**

- Deal Directly With Lender
- Deferred Payment Plans
- No Prepayment Penalty
- No Restriction on Use of Funds For:
  - Investments
  - Payment of Taxes
  - Debt Consolidation
  - Tax Shelters
  - Pension Plan Contributions

Ask for Tom Todd

**CALL TOLL FREE:
800-423-5025**

**Serving The Medical
Profession Since 1966**

**WOODSIDE
CAPITAL
CORP.**

National Headquarters
Woodside Capital Building
21424 Ventura Boulevard
Woodland Hills, California 91364

From One of the Oldest Medical Computer Companies in Michigan

COMPLETE MEDICAL OFFICE COMPUTER DESIGNED FOR MICHIGAN PHYSICIANS

$6300

Includes

- IBM PC XT
- Program
- Training Class

Call or Write Today

Bennethum Computer Systems, Inc.
31811 Middlebelt Rd.
Suite 202
Farmington Hills, MI 48018
313/851-3058

— Since 1968 —

CATEGORY I/Continued

Date: May 6-8, 1985, Hemodynamic Monitoring VIII. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, University of Michigan, Ann Arbor 48109 (313) 763-1400. **Approved for:** 14.5 hours of Category I Credit.

Date: May 8, 1985, Pancreatitis. Location: St. John Hospital. **Sponsor:** CME Committee of St. John Hospital. **For:** Interested physicians. **Cost:** $90.00. Contact: Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road, Detroit 48236 (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: May 9-10, 1985, A Team Approach to Aspiration Biopsy & Workshop on Aspiration Biopsy Cytology. Location: Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313) 876-3073. **Approved for:** 12 hours of Category I Credit.

Date: June 12, 1985, 1985 Geriatrics-Family Practice Update. Sponsor: CME Committee of St. John Hospital. **For:** Interested physicians. **Cost:** $90.00. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road, Detroit 48236 (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: June 20-22, 1985, 35th Annual Keyport-Gaylord Trauma Symposium. Location: Hidden Valley Resort. **Sponsors:** Wayne State University, Department of Surgery, Michigan Committee on Trauma. **Contact:** Theresa Sokol, Wayne State University, Department of Surgery, 6-C UHC, 4201 St. Antoine, Detroit 48201. **Approved for:** 15 hours of Category I Credit.

MEETINGS

MSMS, MSMS/A, AMA & MEDICAL ASSISTANTS

Nov. 13-15 — MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn, contact: Sherry Fent, MSMS headquarters.

Nov. 21 — MSMS Board of Directors meeting, MSMS headquarters, contact: William Madigan, MSMS headquarters.

Nov. 27-29 — AMA Diet and Behavior: A Multidisciplinary Evaluation, Sheraton National Hotel, Arlington, VA, contact: Karen Prupes, AMA, (312) 645-4418

Nov. 29-December 3 — Fourth Assembly Meeting of the AMA Hospital Medical Section, Honolulu, Hawaii, contact: Bruce Ambrose, MSMS headquarters.

December 2-5 — Interim Meeting of AMA House of Delegates, Honolulu, Hawaii, contact: Bruce Ambrose, MSMS headquarters.

February 8-10, 1985 — Medical Assistants Midwinter Seminar, Midway Motor Lodge, Warren, contact: Caroline Rich, MSMS headquarters.

April 26-28, 1985 — 1985 MSMS House of Delegates meeting, Michigan Inn, Southfield, contact: Richard Campau, MSMS headquarters.

June 16-20, 1985 — Annual AMA House of Delegates, Chicago, contact: Bruce Ambrose, MSMS headquarters.

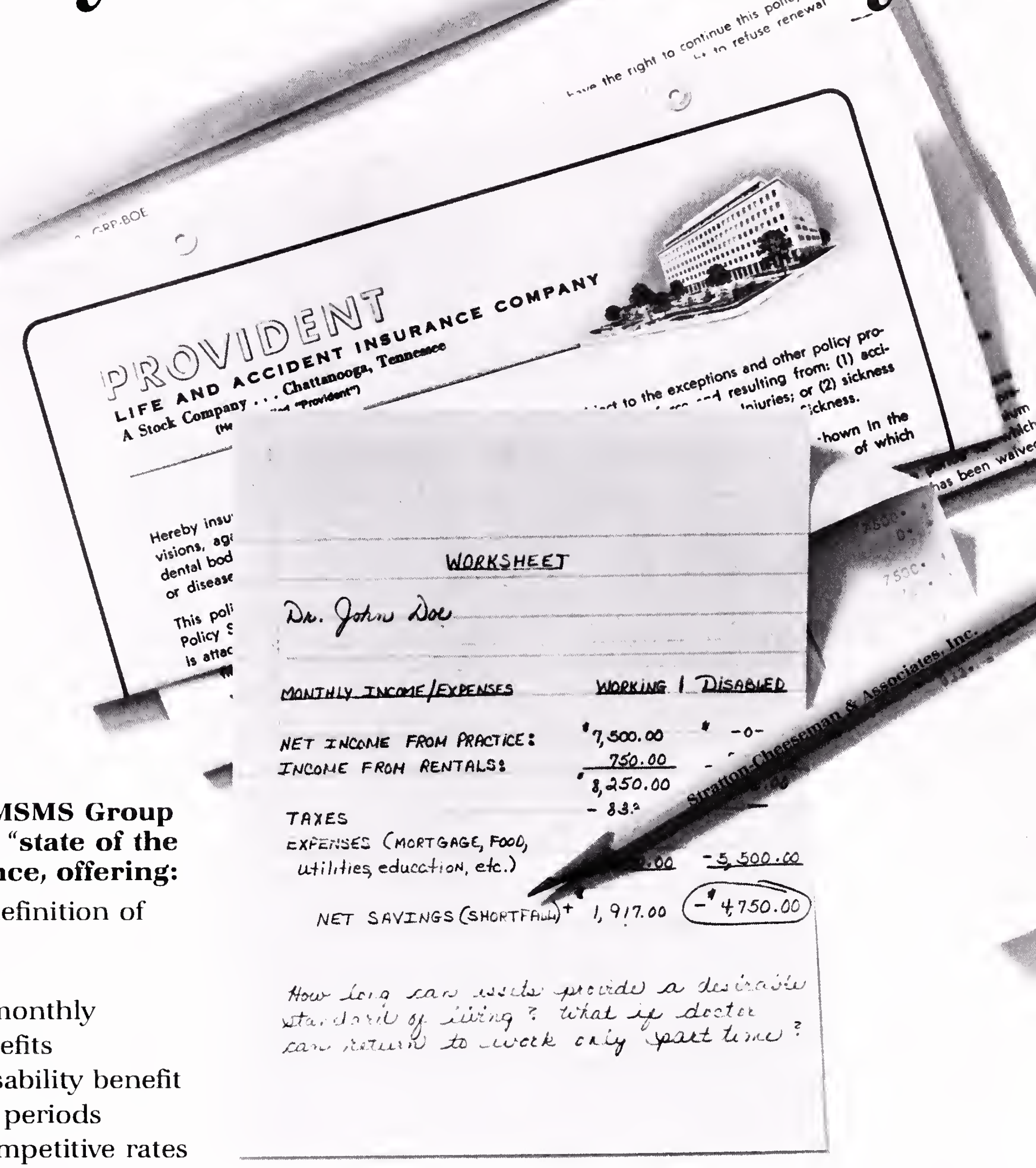
OTHER MEETINGS

Nov. 14 — Michigan Allergy Society, Hyatt Regency, Dearborn, contact: David Seaman, MD, Michigan Allergy Society, 8578 Canton Center Road, Canton, 48187.

Nov. 15 —Michigan League for Human Services Annual Conference, Hyatt Regency, Dearborn, contact: League for Human Services, 300 N. Washington Square, Suite 311, Lansing 48933, (517) 487-5436.

Nov. 19 — Cancer Care Conference, Kellogg Center, East Lansing, contact: Kellogg Center, Michigan State University, East Lansing 48824.

Have You Reviewed YOUR Disability Insurance Lately?



PROVIDENT
LIFE AND ACCIDENT INSURANCE COMPANY
A Stock Company . . . Chattanooga, Tennessee

WORKSHEET

Dr. John Doe

MONTHLY INCOME/EXPENSES	WORKING	DISABLED
NET INCOME FROM PRACTICE:	$7,500.00	$ -0-
INCOME FROM RENTALS:	750.00	-
	$8,250.00	
TAXES	- 833.	
EXPENSES (MORTGAGE, FOOD, utilities, education, etc.)	.00	-5,500.00
NET SAVINGS (SHORTFALL)+	1,917.00	-$4,750.00

How long can assets provide a desirable standard of living? What if doctor can return to work only part time?

The new, improved MSMS Group Disability plan is the "state of the art" in group insurance, offering:

"Your own specialty" definition of disability
Lifetime benefits
Benefits up to $2,500 monthly
Residual disability benefits
Waiver of premium disability benefit
30 and 90 day waiting periods
Quality coverage at competitive rates
Conversion guarantee

Call or write us today for a review of your coverage and further information about our plans!

This plan is underwritten by Provident Life & Accident Insurance Company, Chattanooga, Tennessee.

Visit us at Exhibit Booth #106 during the MSMS Annual Scientific Meeting.

Stratton-Cheeseman & Associates, Inc.

1305 Abbott Road
P.O. Box 1563
East Lansing, Michigan 48823
Call Toll Free: 1-800-292-1966

MEMBERS IN THE NEWS

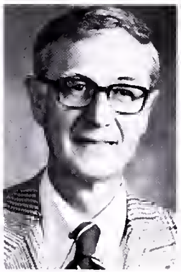
By Sheri Greenhoe
Managing Editor

Ayeni

Bergman

Farooki

Haefele

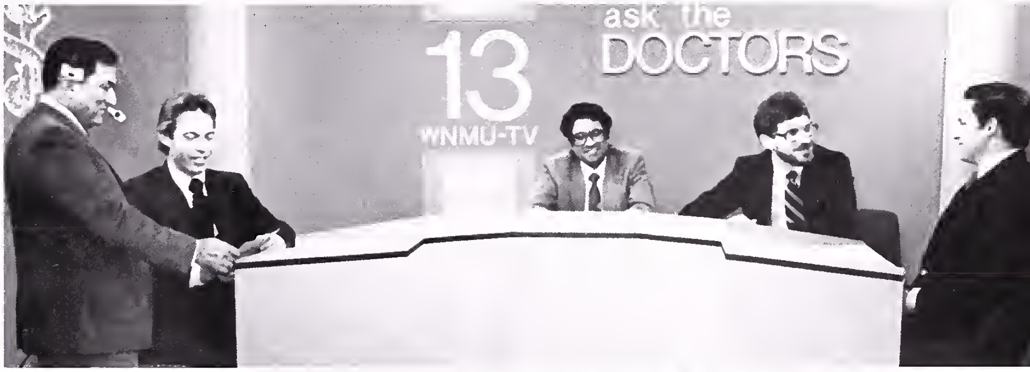


Judge

Fifty-seven years after treating his first patient, **Theodore I. Bauer, MD,** Lansing, retired from the practice of medicine. Doctor Bauer, 88, is a civic activist and in 1978 received the Lansing Regional Chamber of Commerce's Community Service Award. . . . **Lionel E. Dorfman, MD,** past president of the Calhoun County Medical Society was elected vice president of the Battle Creek Symphony Orchestra Board of Directors. . . . **Sylvanus Ayeni, MD,** Marquette, addressed hundreds of emergency medical personnel from throughout the Midwest at the 1984 Upper Peninsula EMS Regional Conference. Doctor Ayeni discussed spinal injuries and their treatment. . . . Prominent member of the Physicians for Social Responsibility, **Eugene Perrin, MD,** Ann Arbor, was one of about 100 American physicians who traveled to the Soviet Union in June. The goal of the trip was to meet with Soviet physicians and discuss ways medical professionals might influence foreign policy. Perrin and his group were able to view Soviet hospitals and health care systems. . . . Albion pediatrician Marta Airala, MD received a certificate of achievement from the Southwest Michigan Perinatal Association, Bronson Hospital, Kalamazoo, for her course of study in its neonatal-infant-child life support program. . . . **Roy T. Bergman, MD,** Escanaba, was elected to membership in the Michigan Upper Peninsula Sports Hall of Fame, and will be inducted during a ceremony in March, 1985. Doctor Bergman has been very active in sports medicine locally, nationally and internationally. . . . **Susan E. Harold, MD,** Franklin, is associate chairman of the Israel Bonds Women's Division, and is chairman of the 1984 Israel Bonds Fashion Show, a fundraising event. . . . New president of the Macomb County Medical Society Auxiliary is **Mrs. Richard Schlappacasse**. **Mrs. Thomas Gignac** was named president-elect. . . . **Leslie Haefele, MD,** Garden City, was honored by his family, patients and friends for his 50 years of medical practice. More than 250 people attended a surprise party for him, and the mayors of both Dearborn and Garden City issued special citations in Doctor Haefele's honor. . . . Another physician marking 50 years in medicine is **Lee Halsted, MD,** Farmington. Doctor Halsted's career was the subject of a feature article in the *Farmington Observer*. . .. **Campbell Cutler, MD,** and his wife Frances, a nurse, are among nine winners of the American Institute for Public Service's Jefferson Award. The Flint couple has helped the poor in Flint, Honduras and Thailand. . . . **Charles L. Seifert, MD,** Lakeview, recently was named that area's Citizen of the Month by the local Kiwanis Club. Earlier Doctor Seifert received the Outstanding Alumnus Award from the Lakeview Board of Education. Both awards stem from Doctor Seifert's active participation in local civic groups. . . . Runner-up in the *Diversion* magazine color photography contest is **Zia Q. Farooki, MD,** Detroit. . . . A retirement open house attended by patients and friends capped 30 years of medical practice for North Branch physician **Cornell Greavu, MD**. . . . Official physician for the 200-member University of Michigan Symphony Band European tour was **John Hall, MD,** Petoskey. Doctor Hall travelled with the band last spring during a month-long sabbatical. . . . **Donald Bignotti, MD,** and **Donald Campbell, MD,** both of Grosse Pointe, share the Semmes Award presented by the Bon Secours medical staff to house officers who demonstrate exemplary performance and a sympathetic attitude toward patients and their families. The hospital's medical staff also presented Holden Awards for outstanding original papers written by residents. First place winner was **Michael Banka, MD**; second place was **Diane Fredal, MD**; and third place winner was **William Hanna, MD**. . . . **Richard D. Judge, MD,** and **Henry H. Swain, MD,** both of Ann Arbor, have been elected to the governing board of the American Heart Association of Michigan. Doctor Judge will serve on the board of trustees and Doctor Swain was elected president. . . . **Don Good, MD,** Traverse City obstetrician, has been named to the board of directors of Empire National Bank. . . . **Mrs. Peter Duhamel**, Rochester, recently was installed as president of the Oakland County Medical Society Auxiliary. **Mrs. Vellappillil Gangadharan**, Birmingham, is president-elect.. . Six Albion members helped to raise funds for the local high school's renovation by donating fees for athletic physicals. They are **Miriam Daly, MD; Mohammad R. Siddiqui, MD; Anne Cavanaugh, MD; Marta Airala, MD; Ralph A. Cram, MD; and Russell C. Rowan, MD.** ☐

By Robert H. Manning

"Ask the Doctors" show a hit in Marquette



Relaxing on the set of ASK THE DOCTOR, while (standing) Busharat Ahmad, MD, far left, confers with Robert Manning, are (l. to r.) Abdulhamid Kanji, MD, radiation oncologist, Marquette; Daniel Arnold, MD, Medical oncologist, Marquette; and Ellwood Voorhees, MD, surgical oncologist, Sault Ste. Marie.

MSMS is a major underwriter, along with the Marquette-Alger County Medical Society and Marquette General Hospital, Inc., for "Ask the Doctors," the monthly television program on WNMU–TV.

Busharat Ahmad, MD, who until recently was an MSMS district director, serves the local medical society as the physician coordinator to the popular call-in program.

"Ask the Doctors" is now in its seventh year, with Doctor Ahmad serving as the coordinator since the program's inception. "Favorable comments about the high calibre of program concent continue to be received regarding 'Ask the Doctors,' and we are especially proud to be a part of this unique Upper Peninsula program," says Robert C. Neldberg, executive director of Marquette General Hospital.

The program originally ran for a half four. But Robert Manning, producer and moderator, noticed that certain specialists generate many more telephone calls.

Responding to that demand, Bruce Turner, station manager, agreed to slot a full hour for programs that would have special emphasis.

Starting with two one-hour specials in cancer and cardiology, the sponsors expanded efforts to include pediatrics, mental health, and obstetrics/gynecology. In September of 1982 all the programs became a full hour in length, with half devoted to special topics.

"Before the program could be changed to a full hour for the entire season, additional funding was sought. Without the cooperation of Doctor Ahmad and his MSMS leadership, we could not have even considered expanding the show," according to Becky Beauchamp, the station's development director.

The program originates in the studio of WNMU-TV13, the public broadcasting station for the Upper Peninsula, owned by Northern Michigan University. "Ask the Doctors" is one of three regular professional call-in programs produced by Channel 13, the other two being "Ask the Dentists" and "Ask the Lawyers."

Taking calls from viewers are volunteers from the Marquette-Alger County Medical Society Auxiliary. For the past two years, Mrs. Linda Lehtinen has served as the telephone coordinator. Mrs. Kevin (Pat) O'Brien has been a telephone volunteer as long as the program has been aired and has been an inspiration to others to volunteer, particularly in winter months when traveling to the studio is a feat. Another regular on the program is Mrs. Ahmad (Adeeba), who also serves as a telephone volunteer.

Manning repeats a disclaimer during the program admonishing viewers that answers are intended for a large viewing audience and are not intended to diagnose or provide an accurate course of action for a particular patient and problem. Viewers are encouraged to discuss their problem candidly with their own physician, whether or not their question was used on "Ask the Doctors."

Denise Hinkle, promotion director for channel 13, estimates that "Ask the Doctors" is viewed in about 5,000 households and is one of the more popular locally produced programs. ☐

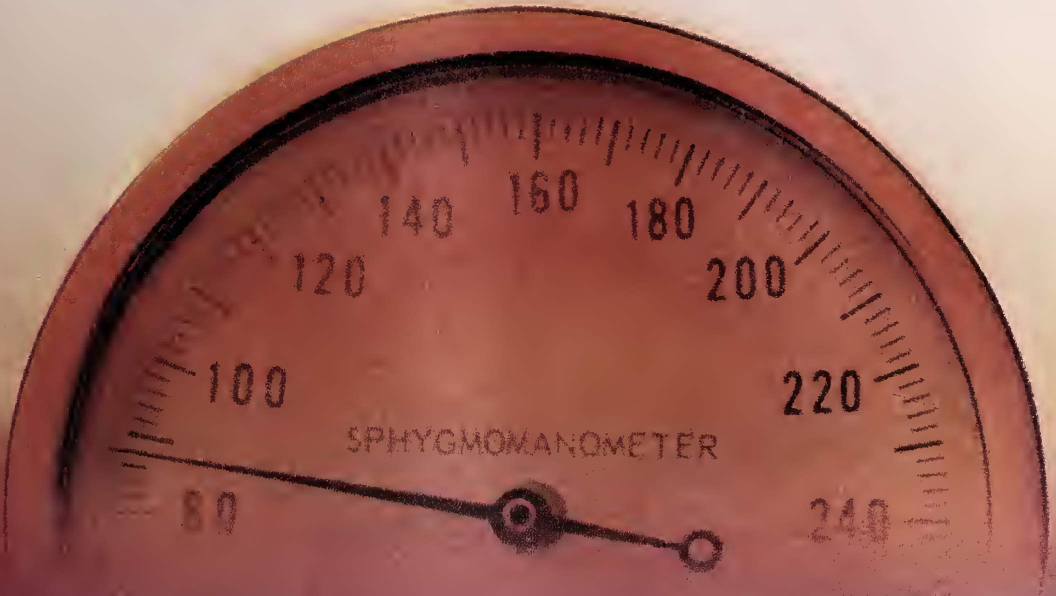
Robert H. Manning is audio-visual director at Northern Michigan University in Marquette. In addition he serves as Executive Director of the Marquette-Alger County Medical Society and is a consultant in audio-visual systems and conference services for a number of health related institutions including the local medical society.

Just once each day...

First-step blood pressure control with optimal simplicity

Benefits diuretics cannot offer. . . Once-daily INDERAL LA (propranolol hydrochloride) with its smooth 24-hour control of blood pressure provides a high degree of patient acceptance without potassium problems, plus the cardiovascular benefits of the world's leading beta blocker.

Experience no other beta blocker can match. . . Once-daily INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.


80
100
120
140
160
180
200
220
240
SPHYGMOMANOMETER

Start with 80 mg once daily... Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES

Just once each day for initial therapy in hypertension.

AL LA
AL LA
AL LA

80 mg	120 mg	160 mg

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

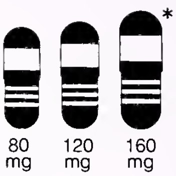
Ayerst.

Just once each day for initial therapy in HYPERTENSION.

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) *LONG ACTING CAPSULES*



Just once each day...

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product INDERAL LA can provide effective beta blockade for a 24-hour period

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Theretore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible)

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris Since coronary artery disease may be unrecognized, it may be prudent to follow the aoove advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors

MAJOR SURGERY. The necessity or desirability ot withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy. Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal. nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS)

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily The usual effective dose range is 160-240 mg once daily The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

8950/284

Ayerst®

AYERST LABORATORIES
New York, N.Y. 10017

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

1st FOR PROFESSIONAL PROTECTION EXCLUSIVELY

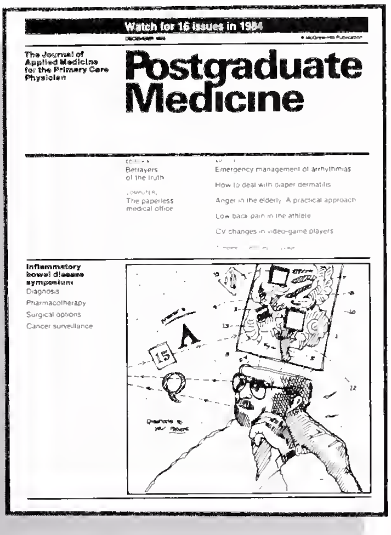
YOUR FIRST STEP TO FIRST QUALITY PROTECTION
CONTACT FIELD REPRESENTATIVES

Eastern Office
JOHN K. GALLOWAY, THOMAS A. WEISMAN, WAYNE M. BACKUS,
CHARLES J. ROWE and MARK A. WHITMAN
6785 Telegraph Road, Suite 350, Birmingham, Michigan 48010
(313) 647-6640

Western Office
GEORGE J. HAWORTH
2600 Five Mile Road, NE, Suite 101
Grand Rapids, Michigan 49505
(616) 361-0863

TURN
TO POSTGRADUATE MEDICINE

Your single, most important source of information on General and Internal Medicine!



Watch for 16 issues in 1984

A McGraw-Hill Publication

The Journal of Applied Medicine for the Primary Care Physician
Postgraduate Medicine

Betrayers of the truth

The paperless medical office

Emergency management of arrhythmias
How to deal with diaper dermatitis
Anger in the elderly. A practical approach
Low back pain in the athlete
CV changes in video-game players

Inflammatory bowel disease symposium
Diagnosis
Pharmacotherapy
Surgical options
Cancer surveillance

Each issue filled with diverse practical information in all areas of medical practice including:
- IM Subspecialties
- Pediatrics
- Obstetrics/Gynecology
- Emergency Medicine
- Other Key Clinical Areas

Read every issue
Postgraduate Medicine
Where Clinical Diversity is an Art.

Myron G. Becker, MD
Edmore

Doctor Becker died August 29 at the age of 92. He practiced medicine in Edmore from 1920 until his retirement in 1972. A graduate of the University of Michigan Medical School, Doctor Becker served as a captain in the US Army Medical Corps, and was past president of the State Bank in Edmore.

John B. Burhans, MD
Grand Rapids

Doctor Burhans died August 20. He was 65. Doctor Burhans had served as assistant professor of surgery at Michigan State University College of Human Medicine, and was former chairman of the ophthalmology division at Blodgett Memorial Medical Center. He maintained a private practice in Grand Rapids from 1957 until 1978.

Harry L. Clark, MD
Ludington

Doctor Clark died September 10 at the age of 97. He was former director of laboratories at Paulina Sterns Hospital, and director of the Oakwood Medical Care Facility. For 30 years Doctor Clark was a professor of medicine at Wayne State University School of Medicine, and he was a founding member of the American Pathology Association.

Harvey Hansen, MD
Battle Creek

Doctor Hansen died August 16 at the age of 81. He had been an orthopaedic surgeon in private practice. Doctor Hansen was a 1927 graduate of the University of Michigan Medical School, and completed his internship and residency at the U-M hospitals. He was an MSMS Council member from 1961 until 1969.

Edward Hier, MD
Alpena

Doctor Hier died August 27. He was 82. A 1926 graduate of Creighton University School of Medicine in Omaha, Doctor Hier served his intership at Detroit's St. Mary Hospital. He practiced medicine for more than 50 years before his retirement, and was past president of the local Lions Club.

Wilfred A. Huegli, MD
St. Clair Shores

Doctor Huegli died September 17 at the age of 74. A graduate of the Wayne State University School of Medicine, Doctor Huegli had been affiliated with Deaconess, Bon Secours and Cottage Hospitals. He practiced as a surgeon and internist in Detroit for more than 50 years, and served in the US Army Air Corps from 1941 until 1946.

Harold F. Jarvis, MD
Detroit

Doctor Jarvis died September 21. He was 73. An obstetrician/gynecologist, Doctor Jarvis graduated from Wayne State University School of Medicine in 1939. He served his internship and residency at St. Mary's Hospital, now Detroit Memorial. He was chief of obstetrics at that hospital for 10 years, in addition to maintaining a private practice. When he retired in 1974 he estimated he had delivered 13,000 babies.

Morris Kazdan, MD
Denton, Texas

Doctor Kazdan, formerly of Allen Park, died June 8 at age 75. A general practitioner, Doctor Kazdan was a Wayne State University School of Medicine graduate. He had been affiliated with Oakwood and Outer Drive Hospitals, Detroit. From 1942 until 1946 he served as a captain in the US Army Medical Corps.

Ned Richards, MD
Saginaw

Doctor Richards died September 7. He was 74. He earned his medical degree in 1937 from Case Western Reserve Medical School. Doctor Richards was a general practitioner, and was affiliated with St. Mary's, Saginaw General and St. Luke's hospitals. He saw action during World War II as a captain in the US Army Medical Corps.

Robert E. Ryde, MD
Escanaba

Doctor Ryde died September 12 at the age of 70. He graduated from the University of Illinois Medical School in 1938, and served his intership at Cook County and Ravenswood hospitals in Chicago. He practiced medicine for 45 years in Escanaba before his retirement in 1983.

Frank Van Schoick, MD
Jackson

Doctor Van Schoick died September 11. He was 83. A pediatrician, Doctor Van Schoick served the patients of Jackson for more than 50 years. He was a 1923 graduate of the University of Michigan Medical School, and taught there for many years. He served as president of the Michigan Heart Association, was state chairman of the Michigan branch of the American Academy of Pediatrics, and was past president of the Jackson County Medical Society.

WHY NOT THE BEST?

With so many life insurance companies in the marketplace today, sometimes it's difficult to choose the one that is best for you.

At American Physicians Life, we offer a comprehensive range of competitively priced insurance products designed with the successful professional in mind including an innovative universal life plan, individual and group term life coverages, qualified pension programs, high-yielding annuity plans, and attractive disability income programs.

APL is represented by the most knowledgeable and professional insurance agents in the industry in addition to being staffed by home office personnel who are dedicated to providing the quality of service a successful professional expects and deserves.

When you are thinking about life insurance protection or planning for a secure future, why not choose a company who understands your particular protection needs—why not choose the best?

AMERICAN PHYSICIANS LIFE
For all your life insurance needs.
A SUBSIDIARY OF PHYSICIANS INSURANCE COMPANY OF OHIO

POLITICS/Continued from page 632

especially health care politics, as I mentioned previously, are largely non-partisan. Therefore, electing just Republicans or just Democrats is not going to solve our problems.

Secondly, the political process generally is not personal. Congress and the President did not pass and sign the Medicare fee freeze because they hate doctors. As a matter of fact, most politicians like doctors. But in that instance, the political pressures to do something were overwhelming. If you were a congressman running for re-election, what would you rather do — anger the doctors in your district or the senior citizens in your district when confronted with the problems of saving the Medicare system from collapse?

The next step

Once we understand the political process more intimately (as distasteful as it is), the next step is to improve our batting average. This next step is not as difficult as one might imagine. Politicians need votes, money, and ideas in order to succeed. We can help them with all three. As amazing as it may seem, there are some estimates that as many as 40 percent of all physicians in the United States are not registered to vote. Of those registered, a large proportion, perhaps more than half, do not vote in general elections, and an even smaller percentage vote in the all-important primary elections.

As for money, we don't need to spend nearly as much on the political process as we do on malpractice insurance in order to have major impact. A $150 sustaining member contribution by every Michigan physician to Michigan Doctors Political Action Committee (MDPAC) and American Medical Political Action Committee (AMPAC) each year would substantially increase organized medicine's effectiveness in this arena. Like malpractice insurance such a contribution is tax-deductible, but unlike malpractice insurance, increasing contributions lead to better results, not poorer results. I ask you, is a $150 total contribution (non-corporate check made out to MDPAC and mailed to P.O. Box 769, East Lansing, Michigan 48823) now and annually until retirement too big a price to pay for a better batting average?

Legislative activity

MSMS has many physicians actively involved in the legislative process, backed up by highly qualified staff members of the Department of Government Relations who are dealing with health legislation and ideas on an ongoing basis. You can be a part of this by remaining a loyal member of MSMS and recruiting your colleagues who currently are content to let you carry the load.

At the AMA level there is an intensive and highly professional legislative effort, but here, too, we witness significant freeloading. When the AMA sought injunctive relief against the provisions of the Medicare payment freeze, it did so on behalf of all physicians. Sadly, less than half of the physicians in the United States belong to the AMA, and among members of the Michigan State Medical Society, one-fourth decide for one reason or another not to pay AMA dues.

Politics and medicine — the challenge is an exciting and manageable one. It's up to us individually and collectively to live up to the challenge. □

PRACTICES FOR SALE

GENERAL PRACTICE — Allen Park area. Fantastic location. Shows a nice profit and has rental income. Perfect satellite office.

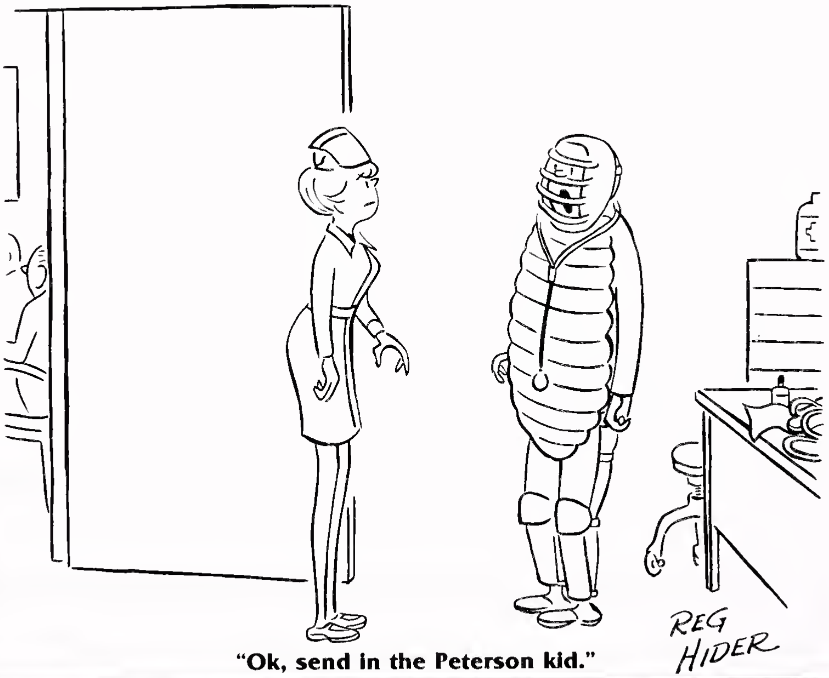
INTERNAL MEDICINE — Hospital-based practice with net income of $200,000. Plenty of good equipment.

GENERAL PRACTICE — Howell area. The "only" practice in lovely downtown Howell. Easy access to major highways. Nice equipment & furniture in large office. **Very attractive terms!**

GENERAL PRACTICE — Westland area. Well-established with plenty of modern equipment. Building and land included. NET EARNINGS $100,000 & UP.

MEDICAL PRACTICE — Lansing area. Industrial and family facility. Equipment in good condition. Also, building is optional.

Professional Practice Sales, Inc.
27208 Southfield Road
Lathrup Village, Michigan 48076
HERBERT SILVERMAN, BROKER
(313) 569-7336



"Ok, send in the Peterson kid."

DON'T BUY A COMPUTER!

A computer can do more damage than good. It may cause you hours of frustration because of record keeping errors, incomplete or incorrect statements, inaccurate forms processing, confusing reports, overloaded capacity, machine malfunctions. Or worse still, it may just sit in your office doing nothing because you can't find someone who understands medical office management to program it.

Without the right software, the computer is useless to you - an expensive mistake. Don't just buy a computer; buy a total solution - an integrated hardware and software system. The Rollins Medical Office Computer System is complete, proven, and ready to go to work in your office. Rollins Medical/Dental Systems specializes in automating health care facilities and has a system specifically tailored to your practice.

Why waste your time looking for someone to program a computer for you when Rollins Medical/Dental Systems has it all done already - not only Accounts Receivable, including insurance form processing, patient statements and receipts, and aged reports, but also Accounts Payable and Payroll, if you wish. And Rollins keeps them continually updated to reflect changes in regulations.

Why take a chance with Brand X hardware either? Rollins Medical Office Systems run on IBM hardware, the most advanced and reliable machines, backed up by the best service available. And Rollins Medical/Dental Systems offers a variety of systems on different machines, depending on the size and nature of your practice.

Don't just buy a computer. Buy hardware and software that work together dependably. We have the system you need for your office already developed, tested and proven. Just fill out this coupon or give us a call. We'll be happy to show you what a difference it could make in your practice management.

ROLLINS
Medical / Dental Systems
360 Clausen Building
23100 Providence Drive
Southfield, Michigan 48075-3677
Phone (313) 423-7200

An IBM value-added remarketer

YES I'd like to know more about the Rollins Medical Office System

Name ______________________________
Practice Name ______________________________
Address ______________________________
City ______________ State ______________
Zip ______________ Phone ______________

Mail to: **ROLLINS Medical/Dental Systems**
360 Clausen Bldg., 23100 Providence Dr
Southfield, MI 48075-3677

The rate for each classified advertisement in *Michigan Medicine* is 20¢ per word, with a minimum charge of $10.00. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

POSITIONS OPEN

RESEARCH ASSOCIATE IN PSYCHIATRY wanted for research involving observation of inpatient and outpatient psychiatric patients behavior; analyze and prepare data obatined from research for publication; required MD in Medicine and one year experience in psychiatric teaching or research; $32,000.00 per year; 40 hours per week. Send resume to 7310 Woodward Avenue, Room 415, Detroit 48202. J.O. #35784 "Employer Paid Ad."

CHAIRMAN - MENTAL HEALTH DEPARTMENT. Assume leadership of growng department with over thirty skilled professionals in Adult Psychiatry, Child Psychiatry, Chemical Dependency Counseling, Psychologists, Social Workers, and Masters Level Nurse Practitioners. Direct further expansion of established, financially stable organization providing a full range of mental health services including individual therapy, pharacotherapy, family therapy, group therapy, conjoint therapy, biofeedback and chemical dependency counselling to 200,000 people in one of America's leading metropolitan areas. Must be oriented toward short term therapy wih proven experience in management. Challenging position for innovative, progressive individual in association with a leader in prepaid health care for twenty-seven years. Direct curriculum vitae to: Paul Brat, MD, Medical Director, Group Health, Inc., 2829 University Avenue Southeast, Minneapolis, Minnesota 55414. An equal opportunity employer.

READY FOR A CHANGE OF PACE? The Air Force has openings for physician specialists. You can enjoy regular working hours, 30 days of vacation with pay each year, worldwide travel opportunities and a unique and enjoyable lifestyle for you and your family, while serving your country. Ask a health professions recruiter about our outstanding pay and benefits package. Call collect: (313) 561-3405.

BOARD CERTIFIED OR BOARD ELIGIBLE OB-GYN OR FAMILY PRACTICE to join or assume very active practice in S.E. Michigan. American graduate preferred. Excellent local hospitals with open staffs. All specialities available in area. Send CV to Box 71, Michigan Medicine, 120 W. Saginaw, East Lansing 48823.

ATTENDING PHYSICIAN - EMERGENCY ROOM. Applications are invited for this position in the Metropolitan Detroit area. Duties include managing patients in the emergency room as well as providing urgent care to in-patients as needed. Must be an MD licensed to practice in the state of Michigan with three years of training in internal medicine. Hours will vary, $20.00/hr. Submit resumes to the Michigan Employment Security Commission, 7310 Woodward Avenue, Room 415, Detroit 48202. Reference #24784.

IMMEDIATE OPENING FOR GENERAL PRACTICE -Physician deceased. Three large hospitals in same town - one 4 blocks from office. 23-year-old practice. Five rooms fully equipped plus private office. Routine lab., large waiting room, modern equipment, large practice plus factory account. Flexible arrangements can be made. For further information, call (517) 332-0227 or write, Ms. N. A. Joseph, 2511 Amelia Lane, Lansing 48917.

OPHTHALMOLOGIST, BOARD CERTIFIED OR ELIGIBLE, to join active surgical/medical practice in suburb of Detroit. Full-time. Excellent opportunity. Reply with CV to Box 70, Michigan Medicine, 120 W. Saginaw, East Lansing 48823.

MICHIGAN, UPPER PENINSULA: Full-time emergency position available with an expanding department which has medium volume ED visits. Independent contractual relationship. Flexible scheduling and annual compensation of at least 78K. Previous ED experience and family practice or surgery background desired. Write or call Tom Campbell, Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186; (414) 785-6500.

SURGEON SPECIALIZING IN COLON AND RECTAL SURGERY. Must be Board Certified in surgery with Michigan medical license. 4 years resident training in surgery with one-year experience required. Salary $60,000.00 per year, 40 hour week. Send resumes to 7310 Woodward Avenue, Room 415, Detroit 48202, Reference No. 33084, Employer Paid Ad.

HENRY FORD HOSPITAL FAIRLANE CENTER is seeking physicians in General Internal Medicine, Obstetrics & Gynecology, Emergency Medicine, Dermatology, Pediatrics, Orthopaedics, Family Practice and other specialties. Send CV to Michael E. Somand, MD, Medical Director, Henry Ford Hospital Fairlane Center, 19401 Hubbard Drive, Dearborn 48126.

LOCUM TENENS POSITION AVAILABLE for Family Practitioner for the months of January through May 1985 at CIGNA Healthplan, an established, growing, progressive prepaid group practice in Phoenix, AZ. An opportunity to practice in a desirable environment coupled with a leisurely southwestern lifestyle. Please submit CV to: Director, Physician Recruitment, CIGNA Healthplan, P.O. Box 44678, Dept. LTM, Phoenix, AZ 85064, (602) 954-3506. EOE

GENERAL SURGERY RESIDENCY PROGRAM DIRECTOR needed by 210 physician multispecialty private group practice in central Wisconsin. Board certified general surgeon with subspecialty training and interest in peripheral vascular surgery plus strong academic interests are being considered. This surgeon would join a seven member General Surgery Section with subspecialty expertise and experience. A clinical appointment through the University of Wisconsin Medical School is available as are research opportunities. Please call Gail H. Williams, MD, Surgery Department Chairman, or Sidney E. Johnson, MD, Medical Director collect at (715) 387-5609 and (715) 387-5253 respectively or send curriculum vitae to: Gail H. Williams, MD, Chairman, Department of Surgery, Marshfield Clinic, Marshfield, WI 54449.

MEDICAL RESIDENT IN PEDIATRIC ANESTHESIOLOGY wanted for diagnosis, treatment, evaluation and preparation of pediatric patients for anesthesia including administering anesthesia with follow-up care for patients' post anesthesia under supervision of hospital staff. Requires MD in Medicine and one year training as a Resident in Anesthesiology. $26,000.00 per year; 40 hours per week. Send resumes to 7310 Woodward Ave., Room 415, Detroit 48202. Ref. No. 32284. "Employer Paid Ad"

OB/GYN BOARD CERTIFIED OR BOARD ELIGIBLE to join progressive 12 physician multi-specialty group practice. Advantages of rural setting with metropolitan practice style. 25 miles from Minneapolis. Offers opportunity to develop OB section for progressive clinic with large geographical referral area. New fully equipped practice facilities are adjacent to a modern 110 bed hospital. Guaranteed salary and benefits schedule with buy-in option at two years. Send CV to: Doctor Jon D. Wempner, Chief of Staff, Lakeview Clinic, Ltd., 424 State Hwy 5 West, Waconia, Minnesota 55387 or telephone (612) 442-4461.

CLINICAL ASSISTANT PHYSICIAN to write detailed clinical history of patient on first admission; perform complete physical examination of patient including the nervous, respiratory, gastrointestinal and cardiovascular system; maintain management of follow-up cases and report regressions and developments; perform psychiatric examinations in cases involving impotence. Requires MD degree or equivalent with a background in both medicine and psychiatry on a level such as received in rotating internship. Salary: $35,000.00 per year/40 hour week. Location: Port Huron, Michigan. Applicants should send resumes and credentials to: Deloris Hazely, Michigan Employment Security Commission, 7310 Woodward Avenue, Room 415, Detroit, 48202. Refer to number 25284. Equal Opportunity Employer.

PSYCHIATRIST, PART-TIME, TO DO OUTPATIENT psychotherapy in private clinic in Adrian, Michigan, to do evaluations and psychotherapy; not to sign insurance forms or to prescribe medications. An excellent opportunity to work with experienced professionals (PhD, psychologists and MSWs) in pleasant and expanding private practice setting. Adrian, Michigan is located 35 miles southwest of Ann Arbor. Send resume to: Brenda Meisels, ACSW, 3449 Brassow Rd., Saline 48176, or call (313) 429-2463.

WANTED: FULL TIME EMERGENCY ROOM PHYSICIAN to work in a progressive, rural hospital Emergency Room in central Michigan. Flexible hours, good hourly wage with malpractice insurance included. Require ACLS. Contact Clare Community Hospital at (517) 386-9951, Ext 101, 102.

FAMILY PRACTICE-INDUSTRIAL MEDICINE A balanced practice awaits you in beautiful SE Wisconsin, Associate needed to share this rapidly growing practice. Contact Westmound Clinics, 683 Westmount, Waukesha, WI 53186, (414) 549-9100.

CARDIOLOGIST: OPPORTUNITY TO PRACTICE cardiology with well-established practice conveniently located to a large teaching hospital. Duties include supervising and interpreting Treadmills, Holter monitors, 2D and M-Mode Echocardiography performed in office, patient examinations, hospital rounds and cardiac catheterizations. Abilities to do streptokinase and/or angioplasty desirable. Excellent beginning salary and fringe benefits. Located in Pennsylvania. Reply with CV to Box 66, Michigan Medicine, 120 W. Saginaw, East Lansing 48823. Immediate Opening.

FAMILY PRACTICE. GREATER FLINT HMO, a non profit subsidiary of Blue Cross-Blue Shield of Michigan, has several excellent opportunities for Board eligible Family physicians. The staff model HMO is two years old and growing rapidly. It offers the chance for physicians to practice true Family medicine in two beautiful facilities. Competitive salaries and a very attractive fringe benefit package are offered. Interested physicians should contact Doctor William Griz at (313) 733-9500.

PSYCHIATRIST: FULL TIME private or multispecialty group practice in Upper Peninsula of Michigan. Rural University Community. Significant mental health support. Send CV to D. Murphy, 821 Water Street, Hancock 49930.

GENERAL SURGEON - Board certified or board eligible. To join eight member family practice medical center. Have full-time radiologist. Major specialties consult on regular basis. Located at International Falls in northern Minnesota. Near Voyageurs National Park. Year around outdoor recreation abounds. Served by major airline. Population twenty thousand. Send curriculum vitae to Doctor James R. Schuft, Falls Medical Center, Shorewood Drive, International Falls, Minnesota 56649.

MEDICAL DIRECTOR. OPPORTUNITY FOR PHYSICIAN with experience in medical group practice administration to join established HMO in Madison, Wisconsin. Group Health serves 29,000 patients with its staff of 20 physicians and total staff of 180. Excellent salary and benefit program. This represents a rewarding opportunity to develop or progress your career in medical administration. Contact: John Mueller, Group Health Cooperative, 1 South Park St, Madison, WI 53715; (608) 251-4156.

FAMILY PRACTICE. RAPIDLY EXPANDING STAFF MODEL HMO in Madison, Wisconsin, has opportunities for additional family practice physicians. Competitive salary with excellent benefits and attractive practice setting. GHC is an established, rapidly growing HMO serving 29,000 patients. Current staff totals 180 employees, including 20 physicians. Contact: John Mueller, Group Health Cooperative, 1 South Park St, Madison, WI 53715; (608) 251-4156.

OB/GYN. GROUP HEALTH COOPERATIVE has 1984 opening for Board certified/eligible obstetrician and gynecologist. GHC is an established, rapidly expanding HMO. Staff enjoy a stable salary plus excellent benefit program including 5-6 weeks of time off plus $3,000 CME funding. Madison is a city of 200,000 population; University of Wisconsin; and 4 lakes. Contact: John Mueller, Group Health Cooperative, 1 South Park St, Madison, WI 53715; (608) 251-4156.

FAMILY PRACTIONERS, GENERAL PRACTIONERS or Emergency Medicine Physicians-with practice experience wanted for free-standing urgent care centers located in the Central Michigan area. Excellent access to recreational areas. Associate and Medical Director opening immediately. Other vacancies opening in August or September of 1984. Salary negotiable plus fringe benefits. Send C.V. to Contemporary Medical Management, Incorporated, 401 South Euclid Avenue, Bay City 48706 (517) 667-0494.

GENERAL SURGEON, OB/GYN AND INTERNAL MEDICINE SPECIALISTS to join seven doctor Family Practice Clinic in Cloquet, Minnesota, a community of 12,000 (30,000 service area) located 20 minutes from Duluth-Superior. Clinic facility is located one block from modern, well equipped 77 bed hospital. Cloquet enjoys a stable economy (forest products). Additionally, our community is noted for its excellent school system. First year salary guarantee, paid malpractice, health and disability insurance, vacation and study time. Contact John Turonie, Administrator, Raiter Clinic, Ltd., 417 Skyline Blvd., Cloquet, MN 55720. Telephone (218) 879-1271.

POSITIONS WITH THE STATE OF MICHIGAN—Currently taking applications for positions expected to be available in the future. Office locations now include Kalamazoo, Lansing, Southfield, and Traverse City. A board certified or board eligible psychiatrist needed for the Kalamazoo office, and internists desired for other offices. Beginning salary in low 60's with approximately 26% fringe benefits. An equal opportunity employer. All inquiries treated confidentially. For further details, please write: Chief Medical Consultant, Disability Determination Service, PO Box 30011 Lansing, 48909.

FAMILY PHYSICIAN: IMMEDIATE OPENING for a residency trained FP preferring small-town life style and interested in "whole person medicine from the Christian perspective" in a new office in the small college town of Hillsdale in southern Michigan. Write or call: Frederick L. Bean, MD, Hillsdale Family Practice, 111 South Howell, Hillsdale, 49242.

POSITIONS WANTED

OPHTHALMOLOGIST AVAILABLE for locum tenens. Board certified. Also interested in full time or part time position. Contact Box 39, Michigan Medicine, 120 W. Saginaw, East Lansing 48823.

MISCELLANEOUS

GENERAL OPHTHALMOLOGY PRACTICE FOR SALE; established, busy in stable suburb of Detroit. Surgery, medical, contacts, referrals. Excellent opportunity. Respond to Box 70, Michigian Medicine, 120 W. Saginaw, East Lansing, 48823.

OFFICE SPACE FOR LEASE. Lansing Professional space for lease. Modern west side (Delta Twp) occupied by physician for ten years. $395 per month. (517) 323-3716 or (517) 321-5476.

PHYSICIAN OPPORTUNITIES. Bernie Hoffman Associates, Inc. is currently assisting a major metropolitan Detroit health care provider in the expansion of their suburban clinic network. The search for qualified physicians includes the following specialties: Obstetrics and Gynecology, Emergency Medicine, Family Practice, Internal Medicine, Orthopedic Surgery and Pediatrics. The typical statellite center provides an excellent practice setting for a four person physician group. There are over 30 opportunities for board eligible or board certified physicians with available starting dates of 10/1/84, 1/1/85, and 7/1/85. A compensation program emphasizing flexibility and incentive will be explored with invited candidates. Interested physicians should submit curriculum vitae in confidence to: Tim Ignash, Senior Associate, Bernie Hoffmann Associates, Inc., One Northland Plaza, 20755 Greenfield, Suite 601, Southfield 48075 (313) 557-9340.

HOLTER MONITOR SCAN SERVICE — Scanning for cartridge, cassette or reel-to-reel recorders by a company in the medical field for over twenty years. **QUALITY REPORTS PRODUCED BY QUALIFIED TECHNICIANS AND CARDIOLOGISTS.** Reports returned in 24 hours. Recorders and hook-up kits available. For further information call Advance Medical and Research Center 1-800-552-6753.

SANIBEL ISLAND, FLORIDA LIGHTHOUSE POINT condominium completely furnished for sale by owner. Never rented. Pristine condition. 3 bedroom magnificent bay view. Beach. $198,500.00. Assume 9% mortgage. (813) 472-3719 or (317) 251-0321.

1985 CME CRUISE/CONFERENCES ON SELECTED MEDICAL TOPICS — Caribbean, Mexican, Hawaiian, Alaskan, Mediterranean. 7-14 days year-round. Approved for 20 — 24 CME Category 1 credits (AMA/PRA) & AAFP prescribed credit. Distinguished professors. **FLY ROUNTRIP FREE ON CARIBBEAN, MEXICAN, & ALASKAN CRUISES.** Excellent group fares on finest ships. Registration limited. Prescheduled in compliance with present IRS requirements. Information: International Conferences. 189 Lodge Ave., Huntington Station, NY 11746. (516) 549-0869.

Thanks to our advertisers

Advance Medical & Research	585
American Physician's Life	627
Ayerst	552-54, 565-72, 598-600, 613-14, 622-24
Bennethum Computers	618
Blue Cross/Blue Shield of Michigan	603
Brown Pharmaceuticals	575
Eli Lilly	581
HASCO	605
Institute for Health Maintenance	583
Knoll	590-92
Laboratory of Clinical Medicine	610
Marion Labs	595-96
Medical Protective	625
Michigan Conference on Maternal & Perinatal Health	607
Michigan Physicians Mutual Liability Company	576-77
Mini Micro Computers	587
MSMS Program to Assist Impaired Physicians	608
PICOM	609
Postgraduate Medicine	625
Professional Practice Sales	628
Roche	IBC, BC
Rollins Medical/Dental Systems	629
St. Mary Of Nazareth Hospital	611
Stratton-Cheeseman	619
Upjohn	593-94
Woodside Capital	617
Worldwide Financial Seminars	582

WHY PAY PER SCAN? Lease brand new ACR Holter Recorder for under $70.00 per month! Medical Leasing Company, (313) 879-8860.

FOR LEASE. PRIME, NEW PROFESSIONAL office space in the Union Lake - West Bloomfield area, Oakland County. New Professional office building in what will be the place to go for health care. A place with identity. Growing area, with solid base of older homes. One of the best locations in the Tri County area. Ideal area for specialists of any kind as they are needed. Custom designed suites from 800 to 6000 square feet. Great place to live. For information call (313) 363-0365 or 625-0660.

FOR SALE. MARCO ISLAND CONDOMINIUM, high-rise, on the beach. Beautiful Gulf of Mexico view and island view. Two bedroom - two and one-half baths- approximately 2000 square feet. All amenities. For the discriminating buyer. Decorator furnished. Call area (313) 651-3871.

DOCTOR, YOU CAN'T BEAT THE QUALITY OR THE PRICE! Holter Monitor scanning service. Physician owned, trained and supervised. $35.00 for cassette reports: $45.00 for reel to reel reports; No contracts to sign. We can arrange for lease/purchase of Holter equipment. Why are you paying more and getting less? DCG Interpretation (313) 879-8860.

ATTENTION DOCTORS: We have previously owned medical, laboratory, office and x-ray equipment in excellent condition. We buy, sell, broker and repair. Office appraisals available by certified surgical consultants. Call Doctor Medical Resale at (313) 569-4407 9 AM - 9 PM.

PHYSICIAN SIGNATURE LOANS TO $50,000. Up to 7 years to repay. No prepayment penalties. Prompt, courteous service. Competitive fixed rate, with no points, fees or charges of any kind. Physicians Service Association, Atlanta, GA Toll-free (800) 241-6905.

Toward understanding the politics of health care

Four years ago I attended a briefing in Chicago by Wayne Bradley, vice president for public affairs of the American Medical Association, on the 1980 Presidential election results and their implications for organized medicine.

Mr. Bradley was addressing the AMA Council on Legislation, on which I serve, and was tempering our euphoria over the Reagan electoral landslide with sage advice on political reality. At that time Mr. Bradley warned us that it is often better to have our philosophical opponents in power than our friends.

His point then, reiterated on several occasions since, was that it is much more difficult to fight and win political wars against friends than it is against opponents. A case in point is the fairly recent Medicare fee freeze, mandated under the Deficit Reduction Act. This act was passed by a Democratic House and a Republican Senate, and signed without protest by a conservative Republican president. The provisions of this portion of the act were so onerous and discriminatory against physicians that the AMA wisely sought injunctive relief in federal court.

Who were our friends and who were our enemies in this particular piece of legislation? I'm not sure anyone, including our AMA Washington lobbyists, can answer that. What is increasingly apparent to me is that health care politics is to a large measure nonpartisan and will be with us for the indefinite future.

Louis R. Zako, MD
MSMS President

Two principles

Further, it is becoming increasingly apparent to me that there are two overriding principles in politics: election and re-election. All other principles are subordinate, except for martyrs and losers, both of which are few in number. Before a candidate for public office can implement a vision for a greater America, he or she must win, and win, and win again.

If you or I were candidates for public office, who would we rather risk angering, those who vote or those who don't vote? (Contrast the voting records, for example, of senior citizens and the 18-30 age group.)

A fascinating example of the political process in action at the state level was the lineup of supporters and opponents of Proposal C, the Voters' Choice constitutional amendment, which mandated state and local non-voted taxes at December, 1981 levels. The opponents outspent the supporters by nearly 15 to 1. Among the opponents were the governor, legislative leaders from both parties, AFL-CIO, the Michigan Education Association, New Detroit Inc., the Michigan Hospital Association, Ford Motor Company, General Motors and Michigan Bell. Supporters of Proposal C were almost exclusively individuals, chief among whom were Doctor Walter Averill of Saginaw, Richard Headlee, and Richard Chrysler, a wealthy small business man. Draw your own conclusions on how the political process really works.

Clear choices

If this is what politics *really* is, how are we physicians going to respond? To me there are some very clear choices.

First of all, it seems to me, resignation and apathy are not comfortable or protective defense mechanisms. Our professional standards, ethics, and aspirations are under continuous attack, an attack that won't abate, simply because we are weary of fighting back. On the other hand, if we are to fight back, for how long and how successfully?

How can we become more effective? First, we must understand the process better. Politics,

Continued on page 628

COMPLETE LABORATORY DOCUMENTATION[1-5]... EXTENSIVE CLINICAL PROOF

FOR THE PREDICTABILITY CONFIRMED BY EXPERIENCE

DALMANE® Ⓒ
flurazepam HCl/Roche

THE COMPLETE HYPNOTIC PROVIDES ALL THESE BENEFITS:

- Rapid sleep onset[1-6]
- More total sleep time[1-6]
- Undiminished efficacy for at least 28 consecutive nights[2-4]
- Patients usually awake rested and refreshed[7-9]
- Avoids causing early awakenings or rebound insomnia after discontinuation of therapy[2,5,10-12]

Caution patients about driving, operating hazardous machinery or drinking alcohol during therapy. Limit dose to 15 mg in elderly or debilitated patients. Contraindicated during pregnancy.

DALMANE® Ⓒ
flurazepam HCl/Roche

References: 1. Kales J *et al*: *Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A *et al*: *Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A *et al*: *Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A *et al*: *Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol 3*:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **9.** Amrein R *et al*: *Drugs Exp Clin Res 9*(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol 3*:303-326, May 1981. **11.** Greenblatt DJ *et al*: *Sleep 5*(Suppl 1):S18-S27, 1982. **12.** Kales A *et al*: *Pharmacology 26*:121-137, 1983.

DALMANE® Ⓒ
flurazepam HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults*: 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients*: 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE®
Roche Products Inc.
Manati, Puerto Rico 00701

DOCUMENTED IN THE SLEEP LABORATORY[1-5]...

PROVEN IN THE PATIENT'S HOME

FOR A COMPLETE NIGHT'S SLEEP

DALMANE® Ⓒ IV

flurazepam HCl/Roche

STANDS APART

15-MG/30-MG CAPSULES

See preceding page for references and summary of product information.

Copyright © 1984 by Roche Products Inc. All rights reserved.

STACKS

MICHIGAN MEDICINE

DECEMBER 1984 JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Vol. 83, No. 58

Member benefits and programs

225 0000000000 123185
SERIALS DEPT - LIBRARY
COLLEGE OF PHYS OF PHILA
19 SOUTH 22ND STREET
PHILADELPHIA, PA 19103

LLEGE OF PHYSICIA
OF PHILADELPHIA
DEC 28 1984
D.S

Whom To Call At MSMS Headquarters

Executive Director: Bruce W. Ambrose
Managing Director: William E. Madigan

Address changes	Peg Berry
Advertising (in *Michigan Medicine*)	Sheri Greenhoe
AMA Delegation	Bruce Ambrose
Annual Scientific Meeting Program	Sherry Fent
Arbitration	Richard Campau
Auto Lease Plan	Wayne Burmeister
Blue Cross Blue Shield/Third Party Payors	John Richards
Board of Medicine	Kevin Kelly
Continuing Medical Education	
Accreditation	Katie Brewbaker
Category I Calendar (for *Michigan Medicine*)	Joyce Crum
MSMS-Sponsored Conferences	Sherry Fent
Dues Billing & Payments	Peg Berry
Financial Operations	Richard Campau
GTE/MINET	Ellen Vinocur Potash
HMOs/PPOs	John Richards
Hospital Medical Staff Relations	Thomas White
Impaired Physicians	Katie Brewbaker
Jail Health Project	Richard Campau
Judicial Commission	Vada Davis
Legislation	Kevin Kelly
Maternal Health Conference	Sherry Fent
Medicaid	Kevin Kelly
Medical Assistants	Caroline Rich
Medical Care Costs	John Richards
Medical Ethics	Vada Davis
Medicare	Debbie Zannoth
Medigram	Judy Marr
Member Services (Including insurance programs)	Wayne Burmeister
Membership Records	Peg Berry
Michigan Association for Medical Education	Vi Heins
Michigan Doctors Political Action Committee	Kevin Kelly
Michigan Chapter, American College of Surgeons	Vi Heins
Michigan Medicine (MSMS Journal)	Judy Marr, Sheri Greenhoe
Michigan Society of Anesthesiologists	Caroline Rich
Michigan Society of Internal Medicine	Caroline Rich
Michigan Society of General Surgeons	Caroline Rich
Michigan Society of Pathologists	Vi Heins
Michigan Society of Respiratory Therapists	Caroline Rich
MSMS Auxiliary	Vi Heins
MSMS Committee Meeting Schedule	Katie Brewbaker
MSMS House of Delegates Agenda and Schedule	Richard Campau
MSMS Meeting Facilities	Linda Munson
MSMS Travel Programs	Donna Farougi
Patient Information, MSMS PR Materials	Kirk McMurray
Physician Legislative Network	Daniel Farhat
Physician Service Group, Inc.	Vada Davis
Practice Management	John Anthony
Professional Liability Insurance	Richard Campau
Public Health	Kevin Kelly
Public Relations	Sherry Wellman
Specialty Societies	Sherry Wellman

Michigan State Medical Society Membership Insurance Benefits

Are you aware of the insurance available to you as an MSMS member?

On the following two pages is a summary of the member benefit insurance coverages which are available to you through the Michigan State Medical Society. All members are encouraged to review this information to be fully aware of all the benefits available and to determine if and where these coverages may fill a void or supplement your existing insurance program.

Any questions or comments regarding these programs may be directed to Wayne Burmeister, manager, Department of Membership, Operations and Meeting Planning, Michigan State Medical Society Headquarters, 120 W. Saginaw, East Lansing, 48823 (Telephone — 517/337-1351).

Please remove this insert for handy reference in your files.

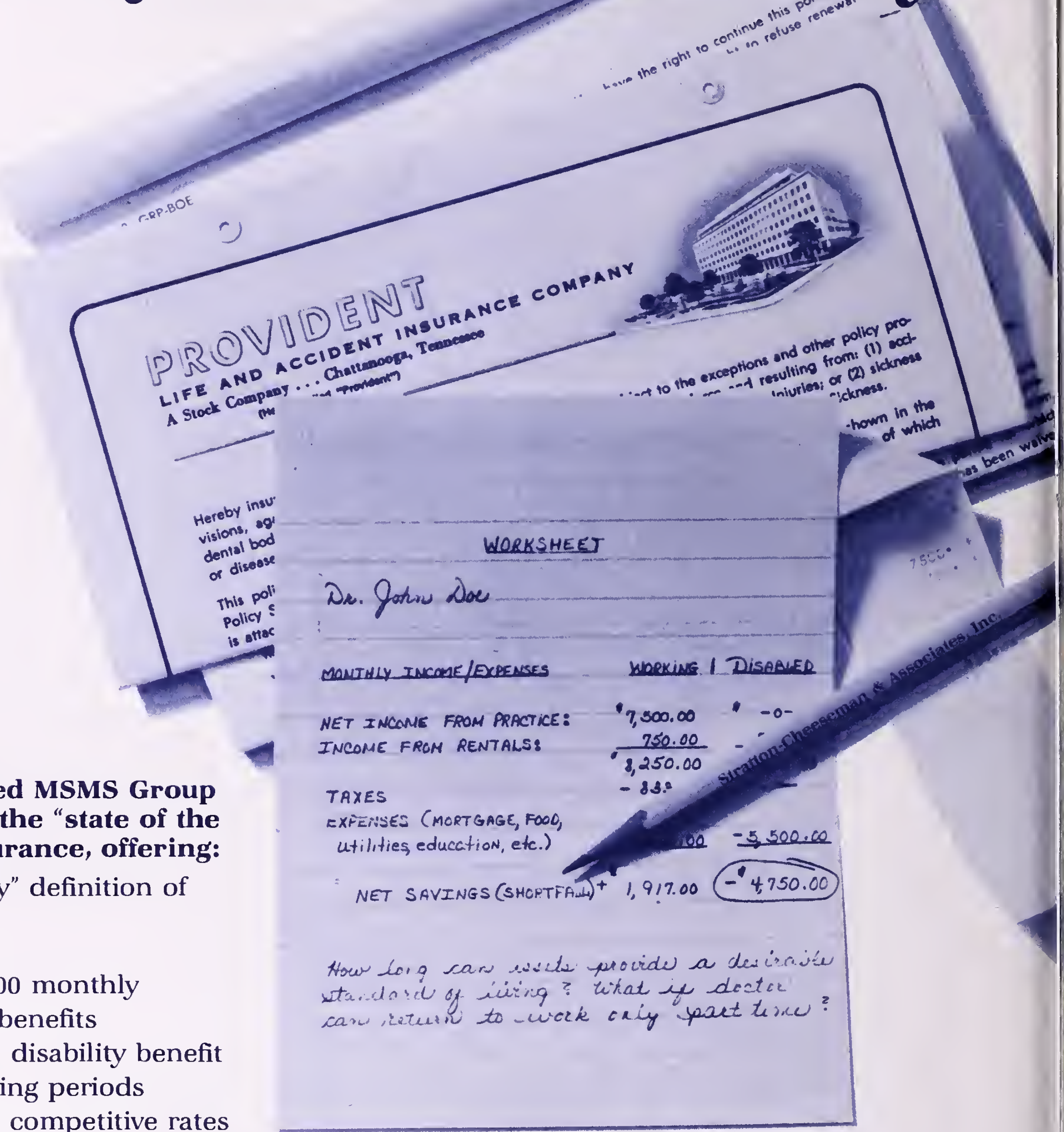
Insurance benefits available for Michigan

Type	Coverage Available	Special Features
1. **Disability Income Protection Accident & Sickness**	Optional amounts up to $2,500 monthly benefit. Benefits paid from the 30th day, or 90th day of disability; and, benefit duration is lifetime for accident and to age 65 for sickness. Coverage automatically includes waiver of premium and up to one-fourth the monthly indemnity for non-disabling injuries. The plan is underwritten by Provident Life & Accident insurance Company, Chattanooga, Tennessee.	"Your specialty" definition of total disability. Residual/partial benefits payable to age 65. New members guaranteed $500 monthly benefit, regardless of medical history. Guaranteed conversion if member leaves the state to continue full time practice in another state. Claims not pro-rated because of benefits received from other insurance.
2. **Business Overhead Disability Coverage**	Optional amounts up to $3,000 monthly benefit. Reimbursement for office expenses; i.e., rent, employees' salaries, utilities, malpractice insurance premiums, etc., during a period of total disability. Benefits payable from the 16th day of disability. Benefits are payable until the Maximum Overhead Expense Benefit Limit is reached — which is the monthly benefit times twenty-four. Waiver of premium is automatically included. The plan is underwritten by Provident Life & Accident Insurance Company, Chattanooga, Tennessee.	Premiums constitute a business expense and are deductible from gross income before taxes (IRS, 55-264, I.R.B. 1955-19, p. 8).
3. **Term Life Insurance**	Available in amounts of $25,000, $50,000, $75,000 or $100,000. Renewable to age 70 (amount reduced at age 65). Waiver of premium is included. Full conversion available to the Permanent Life Insurance Plan after policy is in force one year. This plan is underwritten by The Mutual Benefit Life Insurance Company, Newark, New Jersey.	New MSMS members guaranteed $25,000, regardless of medical history. Participating members are eligible to share any dividends that become payable. Guaranteed conversions to ordinary life if membership is discontinued. Conversions also available to Permanent Life at age 65 reduction and age 70 termination.
4. **Special Accidental Death & Dismemberment Benefits**	Provides benefits for loss of life, limbs, or sight as the result of an accident in amounts of $25,000, $50,000, $75,000, or $100,000. Coverage for the spouse may be purchased — the amount will be 50% of the member's principal sum. This plan is underwritten by Provident Life & Accident Insurance Company, Chattanooga, Tennessee.	Around-the-clock protection and world-wide coverage. Sports and recreation as well as professional duties are fully covered. Renewable to age 70.
5. **Disability Income Protection For Employees of Members**	Available in various amounts up to $500 monthly benefit. Choice of 7-day, 15-day, or 30-day waiting period for benefits to begin. Two benefit durations available: one-year accident/one-year sickness; and, five-year accident/two-years sickness. Waiver of premium included. This plan is underwritten by Provident Life & Accident Insurance Company, Chattanooga, Tennessee.	Premium is a tax deductible expense when paid by the employer.
6. **MEDGARD Professional Liability Insurance**	Limits of $100,000/$300,000; $200,000/$600,000; $1,000,000/$1,000,000 available in occurrence policy forms. This plan is underwritten by Michigan Physicians Mutual Liability Company, East Lansing, Michigan — a physician-owned company.	A 75% premium discount to first-year practitioners; 25% discount for second-year practitioners; 50% for most part-time or semi-retired physicians. No charge for P.C./partnership coverage. Premium financing available.
7. **MEDGARD Property & Liability Insurance**	Comprehensive property & liability insurance for physicians' offices and other property. Selection of optional coverages. This plan is underwritten by Michigan Physicians Mutual Liability Company, East Lansing, Michigan.	Broadest all-risk replacement cost coverage. Insurance designed specifically for physicians. Competitively priced. Advantage of one company — total coverage.
8. **Hospital/Medical/Major Medical Dimension III**	Excellent benefits to cover hospital, medical and major medical services. A separate benefit program is available for employees.	Three option coverages available to physicians and their families, from comprehensive total benefits to Dimension III with deductibles and copayments and a lower premium.

State Medical Society members

Administrators	Eligibility/How to Apply
Stratton-Cheeseman & Associates, Inc. 1305 Abbott Road, P.O. Box 1563 East Lansing, Michigan 48823	All MSMS members, under age 66, residing in Michigan, practicing full-time, may apply. Apply to the administrator, Stratton-Cheeseman & Associates, Inc. Call 1-517-351-5780 for applications & information, or Toll Free, (Michigan) 1-800-292-1966.
Stratton-Cheeseman & Associates, Inc. 1305 Abbott Road, P.O. Box 1563 East Lansing, Michigan 48823	All MSMS members residing in Michigan who practice full-time are eligible to apply. Apply to the administrator, Stratton-Cheeseman & Associates, Inc. Call 1-517-351-5780 for applications & information, or Toll Free, (Michigan) 1-800-292-1966.
Stratton-Cheeseman & Associates, Inc. 1305 Abbott Road, P.O. Box 1563 East Lansing, Michigan 48823	All members, under age 70, active full time in a professional position, are eligible to apply. Apply to the administrator, Stratton-Cheeseman & Associates, Inc. Call 1-517-351-5780 for applications & information, or Toll Free (Michigan) 1-800-292-1966.
Stratton-Cheeseman & Associates, Inc. 1305 Abbott Road, P.O. Box 1563 East Lansing, Michigan 48823	All MSMS members, under age 70, engaged full time in their profession in the state of Michigan are eligible to apply. Apply to the administrator, Stratton-Cheeseman & Associates, Inc. Call 1-517-351-5780 for applications & information, or Toll Free (Michigan), 1-800-292-1966.
Stratton-Cheeseman & Associates, Inc. 1305 Abbott Road, P.O. Box 1563 East Lansing, Michigan 48823	Employees, under age 60, who are employed full time by an MSMS member. Apply to the administrator, Stratton-Cheeseman & Associates, Inc. Call 1-517-351-5780 for applications & information, or Toll Free (Michigan), 1-800-292-1966.
Stratton-Cheeseman Management Company, Inc. 1305 Abbott Road, P.O. Box 1563 East Lansing, Michigan 48823	Write or call Michigan Physicians Mutual Liability Company for a free introductory kit. Telephone numbers are: East Lansing (517) 351-1150; Birmingham (313) 647-5550; or toll free (800) 292-1926.
Stratton-Cheeseman Management Company, Inc. 1305 Abbott Road, P.O. Box 1563 East Lansing, Michigan 48823	Write or call Michigan Physicians Mutual Liability Company for specific information. Telephone numbers are: East Lansing (517) 351-1150; Birmingham (313) 647-5550; or toll free (800) 292-1926.
Blue Cross and Blue Shield of Michigan 600 Lafayette East Dept. J113 Detroit, Michigan 48226	Available to all MSMS members and their employees. Enrollment kit is available from MSMS Department of Member Services, 120 W. Saginaw St., East Lansing, 48823 (517) 337-1351.

Have You Reviewed YOUR Disability Insurance Lately?


PROVIDENT
LIFE AND ACCIDENT INSURANCE COMPANY
A Stock Company . . . Chattanooga, Tennessee
WORKSHEET
Dr. John Doe
MONTHLY INCOME/EXPENSES
WORKING | DISABLED
NET INCOME FROM PRACTICE: $7,500.00 $ -0-
INCOME FROM RENTALS: 750.00
$8,250.00
TAXES - 83.
EXPENSES (MORTGAGE, FOOD, utilities, education, etc.) -5,500.00
NET SAVINGS (SHORTFALL) + 1,917.00 -$4,750.00
How long can assets provide a desirable standard of living? What if doctor can return to work only part time?
Stratton-Cheeseman & Associates, Inc.

The new, improved MSMS Group Disability plan is the "state of the art" in group insurance, offering:

"Your own specialty" definition of disability
Lifetime benefits
Benefits up to $2,500 monthly
Residual disability benefits
Waiver of premium disability benefit
30 and 90 day waiting periods
Quality coverage at competitive rates
Conversion guarantee

Call or write us today for a review of your coverage and further information about our plans!

This plan is underwritten by Provident Life & Accident Insurance Company, Chattanooga, Tennessee.

Stratton-Cheeseman & Associates, Inc.

1305 Abbott Road
P.O. Box 1563
East Lansing, Michigan 48823
Call Toll Free: 1-800-292-1966

December 1984, Vol. 83, No. 58

MICHIGAN MEDICINE

MICHIGAN MEDICINE
Member benefits and programs

About the cover

The members of the MSMS Board of Directors are featured on the cover of this annual membership issue. Posed on the bridge suspended over the MSMS lobby, the directors are: (seated, l. to r.) Carl Gagliardi, MD, vice-chairman of the Board; Thomas Berglund, MD, chairman of the Board; Richard McMurray, MD, president-elect; Louis Zako, MD, president, (standing, l. to r.) Marguerite Shearer, MD; Frederick Bryant, MD; Gerald Mandell, MD; Robert Paxton, MD; William Walters, MD; Kenneth Herrington, MD; Henry Domzalski, MD; Justin Sleight, MD; Frank Walker, MD; Thomas Payne, MD; Kornelius Van Goor, MD; James Humes, MD; Leland Holly, II, MD; Kenneth Rowe, MD; Joel Clay, MD; Harvey Andre, MD; Robert Leitch, MD; Robert Burton, MD and Donald Crandall, MD. **Photo by Kim Kauffman.**

In next month's issue of *Michigan Medicine:* "Maternal/Perinatal Health: A Delicate Balance" is the theme of the 1984 Michigan Conference on Maternal and Perinatal Health. Our January issue will feature the complete preliminary program.

Special Report

639 It's been proven there's strength in numbers, and MSMS membership rolls have reached a record high. This month's special report on membership benefits and programs leads off with an article on what's being done to make that membership figure climb even higher. Insurance benefits are summarized on our annual tear-out insert on the facing page, and a pie-chart tells you at a glance where your membership dues go. Forty MSMS committees, their purposes and their members are listed inside, as are directors and staff assistants to component societies. You'll also find an update on the services and programs offered by MSMS subsidiary Physician Service Group, Inc.; Judith Marr; Betsy Moon.

Features

IFC Whom to call at MSMS headquarters
INSERT MSMS member insurance benefits
634 MSMS Board of Directors and district directors
639 Recruitment and retention are the goals of an aggressive MSMS campaign; Judith Marr and Betsy Moon
641 Forty committees shape the society's future
646 Where your dues go — a pie chart
660 Physician Service Group offers solutions to practice problems; Judith Marr
666 Component societies have close ties to Board and staff
679 Can confidential records be subpoenaed? An Amicus Curiae brief by MSMS legal counsel Kerr, Russell and Weber
686 What every physician should know about contracts, a report on the MSMS Contracting Conference; Judith Marr
702 Sparta family physician Thomas Fochtman, MD, wins Plessner Award
704 Public Affairs/Leadership Conference includes discussion of Michigan Board of Medicine; Judith Marr and Thomas White
712 Free breast cancer brochures available now

Departments

635 Letters
648 MSMS/A; Nancy Crandall
655 New members
659 Meetings
662 Financial planning — What to do about a big profit; Katharine S. Brown
664 Board of Medicine actions
692 Medical newsfronts
701 Members in the news; Betsy Moon
702 Deaths
711 Category I courses
714 Classified ads
715 Ad index
716 President's page: Is it really worth it?; Louis R. Zako, MD

Michigan State Medical Society

President	Louis R. Zako, MD, Dearborn Heights
President-elect	Richard J. McMurray, MD, Flint
Immediate Past President	Donald K. Crandall, MD, Muskegon
Secretary	Robert M. Leitch, MD, Battle Creek
Treasurer	Leland E. Holly, II, MD, Muskegon
Speaker	Gerald H. Mandell, MD, Detroit
Vice Speaker	Robert D. Burton, MD, Grand Rapids
AMA Delegation Rep.	Richard J. McMurray, MD, Flint

Board of Directors

Chairman	Thomas R. Berglund, MD, Portage
Vice Chairman	Carl A. Gagliardi, MD, Dearborn

District directors

District 1	Carl A. Gagliardi, MD, Dearborn James J. Humes, MD, Detroit Kenneth J. Ray, MD, Trenton Henry M. Domzalski, MD, Detroit Arthur A. Ulmer, MD, Grosse Pointe Shores Frank B. Walker, MD, Grosse Pointe Farms
District 2	Justin L. Sleight, MD, Lansing
District 3	William D. Walters, MD, Battle Creek
District 4	Thomas R. Berglund, MD, Portage
District 5	Harvey M. Andre, MD, Grand Rapids Kornelius Van Goor, MD, Grand Rapids
District 6	Richard L. Rapport, MD, Flint
District 7	Kenneth B. Herrington, MD, Bad Axe
District 8	Jack L. Barry, MD, Saginaw
District 9	Vickers C. Hansen, MD, Manistee
District 10	Charles L. Oppy, MD, Roscommon
District 11	Robert E. Paxton, MD, Fremont
District 12	Carl Hammerstrom, MD, Marquette
District 13	Kenneth E. Rowe, MD, Hancock
District 14	Marguerite Shearer, MD, Ann Arbor
District 15	Billy Ben Baumann, MD, Pontiac Frederick W. Bryant, MD, Royal Oak Joel W. Clay, MD, Mt. Clemens

Michigan State Medical Society
Bruce W. Ambrose, director

Committee on Publications
Harvey Andre, MD, Grand Rapids, chairman
Frederick W. Bryant, MD, Royal Oak
Vickers C. Hansen, MD, Manistee
Leland E. Holly II, MD, Muskegon
Richard L. Rapport, MD, Flint
Marguerite Shearer, MD, Dexter
Louis R. Zako, MD, Dearborn Heights

Editor
Judith Marr

Managing Editor
Sheri W. Greenhoe

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

MICHIGAN MEDICINE (ISSN 0026-2293) is the official journal of the Michigan State Medical Society, published under the direction of the Publications Committee. Published five times a month, 60 issues, by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $30.00; single copies, $1.50. Additional postage: Canada, $1 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to articles, news, exchanges and advertising should be addressed to Sheri W. Greenhoe and address changes to Peg Berry, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517-337-1351.

© 1984 Michigan State Medical Society

"Neo no-fault" contracts are appealing

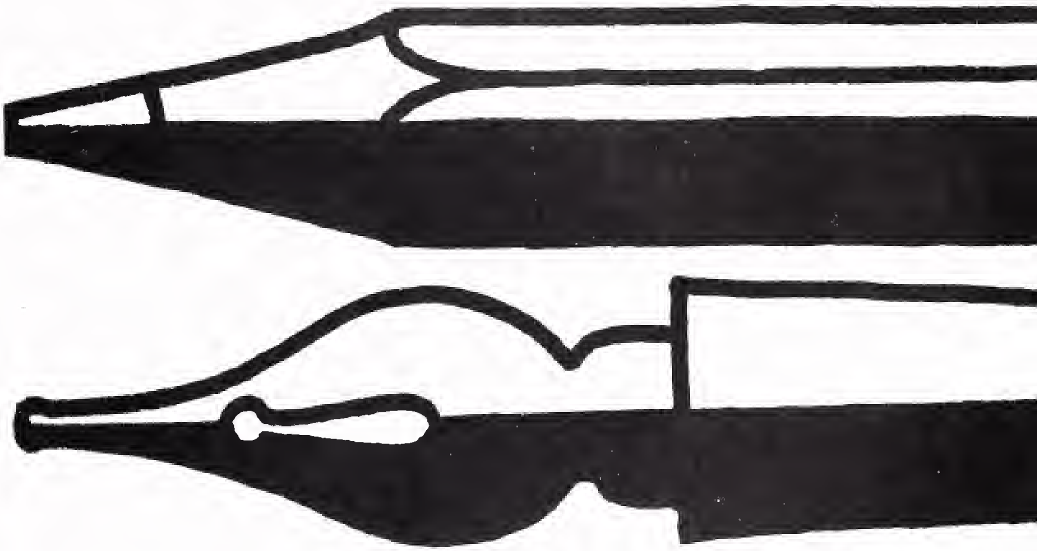
The following letter was sent recently to MSMS President Louis R. Zako, MD.

I thoroughly enjoyed the presentation on "neo no-fault" contracts by Jeffrey O'Connell at the recent Public Affairs/Leadership Conference. It seems to me that MSMS should devote some time, effort and money into pursuing the interest expresssed by many of us in attendance. I, for one, think that trying to resolve the professional liability problem through the legislature or in the courts is an impossibility. The concept of establishing a defined contract is very appealing.

I am very aware that a great deal of study will be necessary before embarking on something as new and revolutionary as preaccident guarantees. I particularly don't like the idea that physicians have to foot the bill for something that may not be their fault. However, there are enough potentially good innovations that we should take advantage of this opportunity. I think the time is ripe for us to consider taking a new tack.

You and the MSMS staff have done an outstanding job of focusing attention on the liability problem. The membership is looking to us for guidance and I hope we can provide it based on intelligent information and serious deliberation.

Frederick V. Minkow, MD
Bloomfield Hills



Medicare's fault

The following letter to the editor appeared in the October 16 issue of The *Lansing State Journal.*

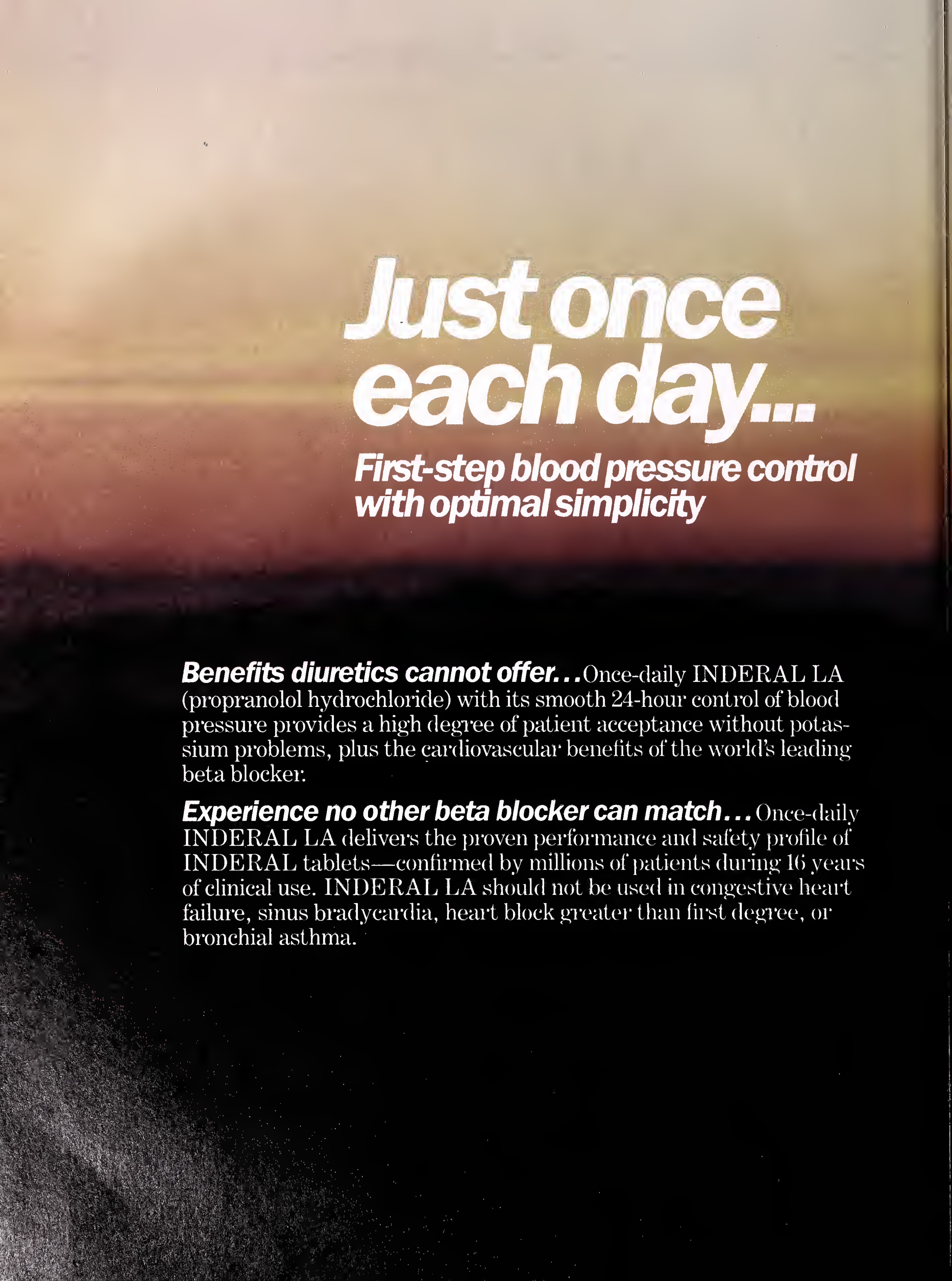
Physicians have been among the first to witness the impact of increasing restrictions related to hospital access for those insured by Medicare. We have wondered if the federal government would ever have us "put people out on the street," and now, apparently, it has.

We recently evaluated and cared for someone we felt needed admission to an acute care facility, yet it was only after evaluations by six physicians in two different hospital emergency rooms over a period of 12 to 15 hours that she finally was admitted. The delay and transfer were due to Medicare policies prohibiting reimbursement if she was hospitalized.

We agree that a vigorous effort should be made to maximize the cost effectiveness of medical services, but also assert that we should make an especial effort to focus on effectiveness as well as cost.

We are sorry that this woman experienced such discomfort and wish not to be associated with governmental and institutional policies that allowed this to happen. We feel the community and its legislators should be made aware of situations like this so that future legislation has our input regarding the effectiveness of health care as well as its cost.

CLIFFORD S. HALE, MD
HELENE DINERSTEIN, MD
Lansing

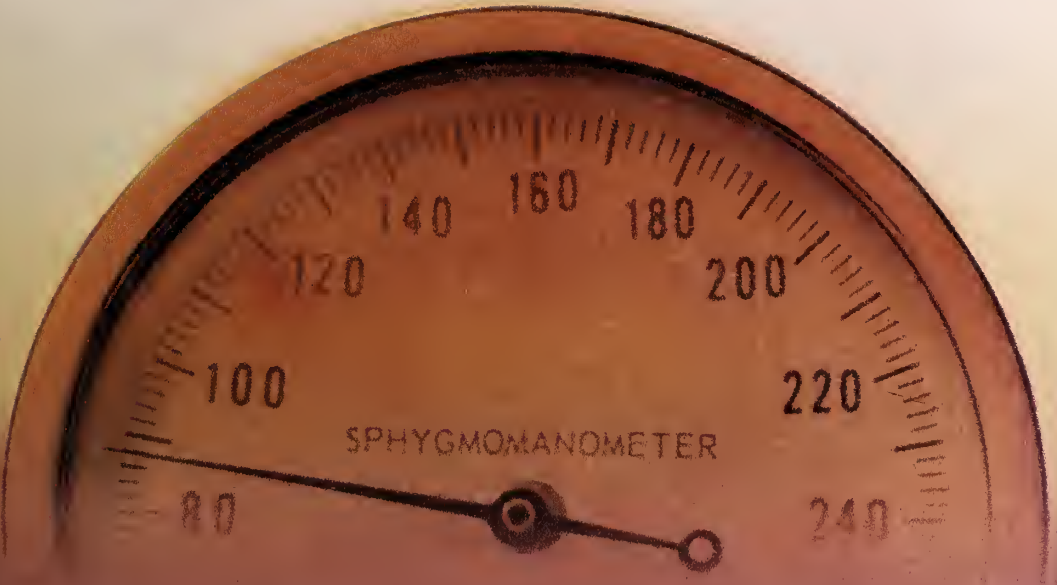


Just once each day...

First-step blood pressure control with optimal simplicity

Benefits diuretics cannot offer... Once-daily INDERAL LA (propranolol hydrochloride) with its smooth 24-hour control of blood pressure provides a high degree of patient acceptance without potassium problems, plus the cardiovascular benefits of the world's leading beta blocker.

Experience no other beta blocker can match... Once-daily INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, heart block greater than first degree, or bronchial asthma.


80
100
120
140
160
180
200
220
240
SPHYGMOMANOMETER

Start with 80 mg once daily... Dosage may be increased to 120 mg or 160 mg once daily as needed to achieve additional control. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCI) LONG ACTING CAPSULES

Just once each day for initial therapy in hypertension.

80 mg 120 mg 160 mg

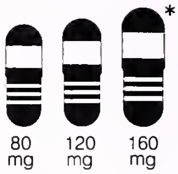
The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories

Ayerst.

Just once each day for initial therapy in HYPERTENSION.

ONCE-DAILY INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product INDERAL LA can provide effective beta blockade for a 24-hour period

The mechanism of the antihypertensive effect of INDERAL has not been established Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm

Propranolol is not significantly dialyzable

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope INDERAL LA also improves exercise performance The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

> IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors

MAJOR SURGERY The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers

DIABETES AND HYPOGLYCEMIA Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose There are no adequate and well-controlled studies in pregnant women INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers: INDERAL is excreted in human milk Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block, hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval

HYPERTENSION—*Dosage must be individualized* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved The usual maintenance dosage is 120 to 160 mg once daily In some instances a dosage of 640 mg may be required The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS)

MIGRAINE—*Dosage must be individualized* The initial oral dose is 80 mg INDERAL LA once daily The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories

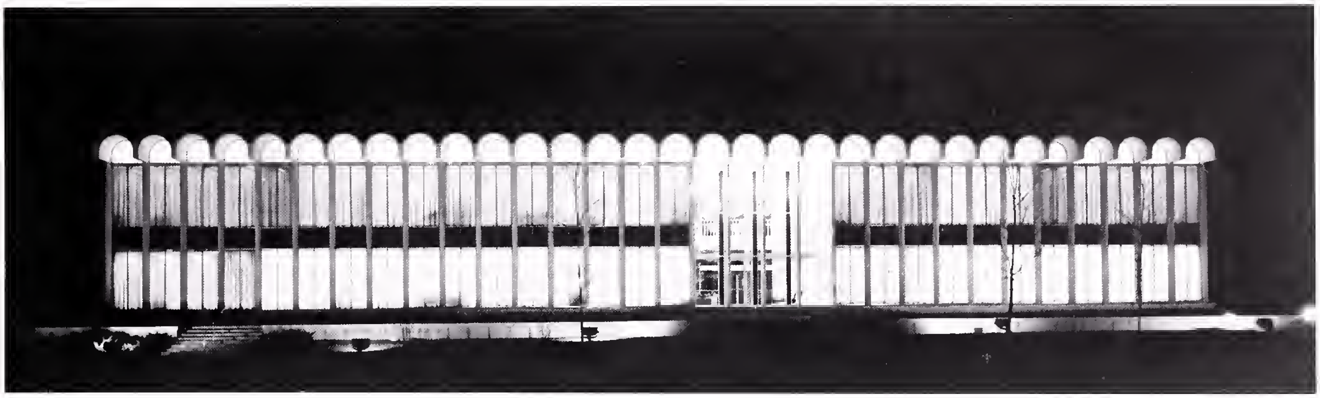
8950/284

Just once each day...

Ayerst. AYERST LABORATORIES
New York, N.Y. 10017

By Judith Marr, Editor
Reported by Betsy Moon

MSMS record membership proves there's strength in numbers



Doctor Anna Broecker wants you for an active MSMS member!

Recruiting new members and keeping them on the active rolls are two of the major goals of Doctor Broecker, who is chairperson of the MSMS Committee on Membership Recruitment and Retention.

The energetic Grand Rapids pathologist and her committee members are heading MSMS efforts to increase membership and make it worthwhile for members to continue with the organization.

At a recent MSMS Board meeting, and again in an interview for *Michigan Medicine,* Doctor Broecker described the major activities of the committee this year.

Targets of its efforts are MSMS members who have not joined the AMA, and vice versa; students; residents; female physicians and foreign medical graduates who are neither MSMS nor AMA members.

"I took this position for the challenge and the opportunity," said Doctor Broecker. "I feel strongly about the need for women to be active in organized medicine. By having a chair, I can practice what I preach."

Strength in numbers

This is a critical time to increase members, according to Doctor Broecker. With the growing economic and governmental pressures on medical practice, physicians must more than ever recognize the strength of their numbers.

In recent years, MSMS has had an active recruitment and retention campaign, much of it carried out in tandem with the membership division of the AMA.

"While great opportunities for growth exist, MSMS and its component medical societies have much to be proud of," said Terry Nugent, director of that AMA division.

At this writing, MSMS has more total members — 10,937 — than ever in its history. That is 851 more members than the 10,086 at the close of 1983. And it's nearly 80 percent of the active practicing physician population in the state.

Of the total MSMS members, 8,093 are active, 279 are in first-year practice, 273 are residents, 616 students, 807 life members, and 655 are retired.

MSMS has 800 of Michigan's 1,400 women physicians as members, and 2,700 of the 4,628 FMGs in the state.

MSMS resident physician membership is up 140 percent in 1984, having increased from 195 in 1983 to 273 in 1984. Student membership is up 80 percent, from 217 in 1983 to 616 in 1984. The resident physician members total just 9.3 percent of the total resident physician population of the state, while MSMS has just 22.6 percent of the state's medical students on its rolls.

Continued on next page

Betsy Moon, Plymouth, is an intern with the MSMS Department of Communications and Professional Relations. She is a senior in Communications at Michigan State University.

MEMBERSHIP/Continued

Michigan has ensured its full complement of AMA delegation members by maintaining its AMA membership levels. Of the 10,076 total AMA members in the state, 7,589 are both MSMS and AMA members, while 2,487 joined the AMA directly, bypassing MSMS.

Membership campaign

Recognizing these potential growth areas, MSMS has drawn up a detailed program for reaching physicians and encouraging them to join the medical society.

New initiatives of Doctor Broecker's committee and her MSMS and AMA staff support include the following:

1. Targeted mailings to special groups. All non-members will receive six general mailings in 1985, and further special mailings will focus on the perceived needs of targeted sub-groups.

2. "Peer to peer" campaigns in May and June, aimed at MSMS and AMA members who have not paid 1985 dues, AMA direct members who are not MSMS members and non-members of both organizations. The campaigns will consist of both personal and telephone contacts.

"In a time when harsh economics make it harder than ever to attract new members," said Mr. Nugent, "there is an urgent need for additional initiatives from MSMS, to be implemented at the county level, in peer-to-peer recruitment.

"Implementation on the county level is dependent on the willingness of the leadership and membership to get actively involved in recruitment and retention."

3. Special activities addressing AMA membership, including letters, committee support of county society efforts to gain AMA members, medical society identification of AMA members, and recruitment ads in MSMS and county medical society publications.

4. One-to-one recruitment of resident physicians by state and county medical society representatives at hospital orientation sessions, and through special literature.

5. One-to-one recruitment of medical students by state and county medical society representatives at freshman orientation and through special literature.

The MSMS retention program is based upon an intensive direct mail dues billing schedule, while begins in late November and continues through July.

Anna Broecker, MD, above right, discusses membership recruitment and retention efforts with Betsy Moon, MSMS student intern. Doctor Broecker's committee has developed an aggressive campaign aimed at specific physician sub-groups which entails direct mailings, peer-to-peer phone calls, promotions and special events. Some elements of the program are implemented at the grassroots level, while others are carried out on a broad scale in cooperation with the AMA.

Clarify and listen

"We're emphasizing the peer-to-peer recruitment," said Doctor Broecker. "This way, we can find out why physicians aren't members, or have dropped their memberships. We can clarify any misinformation anyone may have, and listen to criticisms that may be helpful.

"I believe in the AMA and its goals, and I believe in strength in numbers," she said. "Therefore, I want to work closely with the AMA and take advantage of its resources.

"We are getting tremendous help from the AMA now. It has helped us a great deal in recruiting women physicians. In our inaugural phone-a-thons to recruit AMA members, Terry Nugent flew in to help out. He educated callers on what to say and how to deal with particular questions, and provided us with helpful information."

Grassroots effort

Doctor Broecker encourages local medical society boards and delegates to help with membership development. She wants to involve the local membership leaders in sponsoring non-member residents at local meetings.

"I feel the local leaders would be a very strong and effective group to work with," she said.

With this comprehensive plan and dynamic leader, it's a sure bet more Michigan physicians than ever will be joining MSMS and AMA rolls.☐

Forty MSMS committees shape the society's future

COMMITTEE ON AGING

This Committee examines the health status of senior citizens. Activities include advocating preventative medicine programs and providing physicians with an overview of the medical, social and psychological needs of the aged patient. The Committee works with the Institution of Gerontology and the State Office of Services to the Aging.

William T. Bateman, MD, Chairman, Kalamazoo
Harvey M. Andre, MD, Grand Rapids
Mrs. Donna Chase, Grand Rapids
Diane A. Culik, MD, Detroit
David H. Deitrick, MD, Muskegon
Phillip M. Green, MD, Kalamazoo
Robert E. Holmes, MD, Lansing
Kurt Kratz, WSU
Brooker L. Masters, MD, Fremont
James G. O'Brien, MD, East Lansing
Harry E. Schneiter, MD, Grand Rapids
Robert J. Toteff, MD, Detroit
Richard H. Wakulat, MD, Petoskey
Philip D. Wiley, U-M
Thomas J. Northey, Consultant, Lansing
Janet Olszewski, Consultant, Lansing
Deborah Zannoth, Staff Assistant

PLANNING COMMITTEE FOR MSMS ANNUAL SCIENTIFIC MEETING

The Planning Committee, under the guidance of the Committee on CME Programming, plans and presents Category I Credit courses at the Annual Scientific Meeting. It provides CME courses of value to all specialties while striving to improve methods of education and evaluation.

David R. Rovner, MD, Chairman, East Lansing
Reynard Bouknight, MD, East Lansing
Frederick W. Bryant, MD, Royal Oak
C. Edward Cotton, MD, Marcellus
Dorothy Kahkonen, MD, Detroit
Kenneth L. Krabbenhoft, MD, Detroit
Jeoffrey K. Stross, MD, Ann Arbor
Joan C. Stryker, MD, Detroit
Herbert A. Auer, Consultant, East Lansing
Sherry L. Fent, Staff Assistant

ADVISORY COMMITTEE ON OFFICE AUTOMATION

This Committee advises staff in its plans for automation of MSMS office operations.

Frank B. Walker, MD, Chairman, Grosse Pte. Farms
Jack L. Barry, MD, Saginaw
Leland E. Holly, II, MD, Muskegon
Robert E. Paxton, MD, Fremont
Vada L. Davis, Staff Assistant

LIAISON COMMITTEE WITH AUXILIARY

The Liaison Committee advises the MSMS Auxiliary, on request, regarding Auxiliary activities and problems. It also suggests projects the Auxiliary may wish to undertake.

R. Jack Chase, MD, Chairman, Grand Rapids
Dale R. Drew, MD, Pontiac
Peter A. Duhamel, MD, Rochester
Kenneth H. Musson, MD, Traverse City
Viola Heins, Staff Assistant

COMMITTEE ON AWARDS

This Committee supervises the MSMS award program and makes recommendations to the Board of Directors.

Justin L. Sleight, MD, Chairman, Lansing
Robert M. Leitch, MD, Battle Creek
Frank B. Walker, MD, Grosse Pte. Farms
Katie Brewbaker, Staff Assistant

COMMITTEE ON BIOETHICS

The Committee considers questions about scientific, medical, moral, ethical political concerns dealing with the beginning of life and the ending of life which have raised increasing problems for physicians and therefore MSMS.

Frederick W. Bryant, MD, Chairman, Royal Oak
Howard A. Brody, MD, East Lansing
Anna M. H. Broecker, MD, Grand Rapids
Jeff S. Crumbaugh, U-M
Mrs. Betty Drew, Bloomfield Hills
James T. Harrison, MD, Lansing
John V. Hartline, MD, Kalamazoo
Evan J. Reinders, MD, Muskegon
Marguerite Shearer, MD, Dexter
Angela Tiberio, MSU
Kornelius Van Goor, MD, Grand Rapids
Lester Weiss, MD, Detroit
Sherry N. Wellman, Staff Assistant

COMMITTEE ON CHILD ABUSE AND NEGLECT

The MSMS Committee on Child Abuse and Neglect was established as a focal point for medical concerns related to child abuse. Its purpose is to increase physician awareness about the problems of child abuse and to initiate or participate in programs to promote the detection and reporting of child abuse.

Brooker L. Masters, MD, Chairman, Fremont
Alexa Canady, MD, Detroit
Susan Cline, U-M
Mrs. Dottie Csonka, Essexville
Ann L. Hammon, WSU
Barbara A. Meyer Lucas, MD, Detroit
Ruben S. Kurnetz, MD, Birmingham
Douglas A. Sargent, MD, Grosse Pte. Farms
Jack M. Stack, MD, Alma
Natalia M. Tanner, MD, Detroit
Mark H. Tucker, MD, Battle Creek
Dennis A. Wagner, MD, Sanford
Ray E. Helfer, MD, Consultant, East Lansing
Kevin A. Kelly, Staff Assistant

COMMITTEE ON CONCERNS OF WOMEN PHYSICIANS

This Committee explores ways to encourage the participation and leadership involvement of women physicians in organized medicine.

Vivian M. Lewis, MD, Chairperson, Flint
Susan E. Adelman, MD, Detroit
Joan L. Benner, MSU
Anna M. H. Broecker, MD, Grand Rapids
Frederick W. Bryant, MD, Royal Oak
Miriam S. Daly, MD, Albion
S. Margaret Davies, MD, Chelsea
Linda J. Logsdon, MD, Franklin
Robert E. Paxton, MD, Fremont
Rhoda M. Powsner, MD, Ypsilanti
Marguerite Shearer, MD, Dexter
Christine M. Sullivan, MD, Farmington Hills
Natalia M. Tanner, MD, Detroit
Robert J. Toteff, MD, Detroit
Linda Munson, Staff Assistant

COMMITTEE ON CONTINUING MEDICAL EDUCATION ACCREDITATION

This Committee maintains standards to assure that quality CME activities are available to Michigan physicians, through review, evaluation, and accreditation of continuing medical education providers in the state.

Donald J. Aiken, MD, Chairman, Okemos
Richard F. Willis, MD, Vice-Chairman, Alpena
John A. Baker, MSU
Gail I. Bank, PhD, Detroit
James C. Breneman, MD, Galesburg
Allen D. Damschroder, MD, Petoskey
Roland G. Hiss, MD, Ann Arbor
Joseph F. Marshall, MD, Saginaw
John W. Moynihan, MD, Dearborn
Michael Radke, PhD, Lansing
Robert K. Richards, PhD, Grand Rapids
Victor V. Rozas, MD, Alma
Joseph A. Sentkeresty, MD, Grand Rapids
Robert L. Tupper, MD, Grand Rapids
W. Donald Weston, MD, East Lansing
Charles L. Zeiler, MD, Kalamazoo
Katie Brewbaker, Staff Assistant

More committees on next page

COMMITTEE ON CONTINUING MEDICAL EDUCATION PROGRAMMING

The Committee develops, conducts, and supervises Category I programs in Michigan to serve the continuing medical education needs and interests of physicians. It also is empowered to co-sponsor programs which meet the criteria for Category I programs.

Samuel M. McMahon, MD, Chairman, Lansing
John R. Addy, MD, Lansing
Rudi Ansbacher, MD, Ann Arbor
Frederick W. Bryant, MD, Royal Oak
Merle A. Childers, MD, Rochester
C. Edward Cotton, MD, Marcellus
Richard E. Dean, MD, East Lansing
Clyde R. Flory, Jr., MD, Lansing
Michael J. Giacalone, Jr., MD, Flint
Mary J. Kokosky, MD, Dearborn
Daniel E. Leb, MD, Bloomfield Hills
Richard A. Lemmer, MD, Kalamazoo
Greg Oldford, WSU
David R. Rovner, MD, East Lansing
Joan C. Stryker, MD, Detroit
Nancy Waldenmaier, MSU
Herbert A. Auer, Consultant, East Lansing
James R. Tarrant, Consultant, Detroit
Sherry L. Fent, Staff Assistant

COMMITTEE ON CONSTITUTION AND BYLAWS

This standing committee reviews proposals to amend the MSMS Constitution and Bylaws and presents recommendations for appropriate action by the MSMS House of Delegates. It serves as a reference committee during the House of Delegates meeting.

Earl G. Moehn, MD, Chairman, Mt. Clemens
John W. Hall, MD, Petoskey
Thomas F. Higby, MD, Fowlerville
Murray G. Kling, MD, Detroit
James E. McGillicuddy, MD, Lansing
John H. McLaughlin, MD, Birmingham
B. David Wilson, MD, Kalamazoo
A. Stewart Kerr, Consultant, Detroit
William E. Madigan, ex officio, East Lansing
Vada L. Davis, Staff Assistant

LIAISON COMMITTEE WITH CORPORATE MEDICAL DIRECTORS

The Liaison Committee meets with medical directors of corporations to discuss common interests and recommend appropriate courses of action.

Richard H. Gascoigne, MD, Chairman, Adrian
Duane L. Block, MD, Dearborn
David C. Laderach, MD, Detroit
David Jacknow, MD, Southfield
Thomas C. Payne, MD, Lansing
Kirk McMurray, Staff Assistant

ADVISORY COMMITTEE ON HEALTH CARE POLICY

This Committee recommends MSMS policy on health planning. It encourages physician involvement in health planning issues, monitors activities of health systems agencies (HSA) and the Statewide Health Coordinating Council (SHCC) and assures physician input.

Kenneth J. Ray, MD, Chairman, Trenton
Marguerite Shearer, MD, Vice-Chairman, Dexter
Billy Ben Baumann, MD, Pontiac
Robert B. Carbeck, MD, Ann Arbor
James D. Fryfogle, MD, Southfield
Douglas H. Graham, MSU
George R. Gerber, MD, Rochester
John V. Hartline, MD, Kalamazoo
Terrell K. Hebert, MD, Grand Haven
D. Bonta Hiscoe, MD, East Lansing
Robert A. Mengebier, MD, Petoskey
Donald C. Smith, MD, Farmington Hills
Thomas L. Stackhouse, U-M
Kevin A. Kelly, Staff Assistant

TASK FORCE ON HOME HEALTH CARE

The Task Force oversees the growth of the home health care industry and provides medical input when appropriate. The advent of DRGs promises to release sicker patients to non-hospital settings thereby fueling the growth of this industry.

John V. Hartline, MD, Chairman, Kalamazoo
Morris Brown, MD, Detroit
Brian M. Nolan, MD, Flushing
Lynn M. Podehl, WSU
John Popovich, Jr., MD, Detroit
Larry F. Rawsthorne, MD, Lansing
Charles L. Shabino, MD, Kalamazoo
Marguerite Shearer, MD, Dexter
Theodore S. Vanderveen, MD, Grand Haven
Elliot Wentz, MSU
Kevin A. Kelly, Staff Assistant

STEERING COMMITTEE ON PROGRAM TO ASSIST IMPAIRED PHYSICIANS

The Steering Committee provides assistance to physicians who have problems related to emotional illness, alcoholism, or drug abuse. Education toward prevention, case finding, and intervention are major components of the program.

Carl A. Gagliardi, MD, Chairman, Dearborn
John B. Bryan, MD, Royal Oak
Robert H. Hydrick, MD, Grand Rapids
Joyce W. Mason, MD, Ann Arbor
Steven C. Mason, III, MD, Ann Arbor
Tom R. Miles, DO, Traverse City
Robert Niccolini, MD, Detroit
John T. O'Connor, DO, Lansing
Michael J. Potchen, MSU
David E. Randolph, WSU
Justin L. Sleight, MD, Lansing
Mrs. Marjorie Sleight, Lansing
Ward M. Smathers, MD, Lathrup Village
Russell F. Smith, MD, Whitmore Lake
Katie Brewbaker, Staff Assistant

JUDICIAL COMMISSION

The Commission has sole jurisdiction over matters of ethics, mediation, grievance, and discipline of MSMS members. It has authority to make binding interpretations of the MSMS Constitution and Bylaws and of component society bylaws, as well as rules and regulations governing such matters.

Joseph L. Ponka, MD, Chairman, Detroit
N. Warn Courtney, MD, Kalamazoo
Edwin H. Gullekson, MD, Flint
Murray G. Kling, MD, Detroit
Robert P. Lilly, MD, Livonia
Adam C. McClay, MD, Traverse City
John H. McLaughlin, MD, Birmingham
George W. Morley, MD, Ann Arbor
John C. Rienstra, MD, Grand Rapids
Donald N. Sweeny, Jr., MD, St. Clair Shores
A. Stewart Kerr, Consultant, Detroit
Vada L. Davis, Staff Assistant

COMMITTEE ON STATE LEGISLATION AND REGULATIONS

This Committee monitors and influences Michigan legislation through the legislative process, and monitors and responds to Michigan government rules and regulations as they are promulgated.

Frederick V. Minkow, MD, Chairman, Bloomfield Hills
Robert D. Allaben, MD, Detroit
Mrs. Patricia Allen, Battle Creek
Michael T. Bergeon, MD, Saginaw
Cathy O. Blight, MD, Flint
Anna M. H. Broecker, MD, Grand Rapids
Bruce R. Deschere, MD, Farmington Hills
Douglas A. Dubbink, MSU
Karl J. Edelman, U-M
John A. Feemster, MD, Detroit
Mrs. Lillian Fields, Parma
David L. Harold, MD, Pontiac
Edward L. Harwell, MD, Bad Axe
Richard P. Heuschele, MD, Saginaw
Richard P. Horsch, MD, Farmington Hills
D'Anne M. Kleinsmith, MD, Detroit
James E. MacVicar, MD, Kalamazoo
W. E. Maldonado, MD, Lansing
James E. McGillicuddy, MD, Lansing
Richard D. Nichols, MD, Detroit
Charles L. Oppy, MD, Roscommon
Winifred A. Oyen, MD, Midland
John P. Papp, MD, Grand Rapids
John C. Parker, MD, Jackson
Fred E. Patterson, MD, Ann Arbor
D. Sudhaker Rao, MD, Detroit
Mitchell A. Rinek, MD, Lansing
Edward J. Rutkowski, MD, Traverse City
William C. Sharp, MD, Southfield
Marvin L. Starman, MD, Southfield
Willard S. Stawski, MD, Grand Rapids
Thomas E. Stone, MD, Muskegon
Frank G. VanDeventer, MD, Harper Woods
Charles C. Vincent, MD, Detroit
Frank B. Walker, MD, Grosse Pte. Farms
B. David Wilson, MD, Kalamazoo
Bernard J. Woodley, MD, Trenton
A. Stewart Kerr, Consultant, Detroit
Roger F. Mecum, Consultant, Detroit
Milton Zaagman, Consultant, Lansing
Kevin A. Kelly, Staff Assistant

BOARD OF MANAGERS

Leland E. Holly, II, MD, Chairman, Muskegon
Richard J. McMurray, MD, Flint
C. Allen Payne, MD, Grand Rapids
Robert E. Paxton, MD, Fremont
Justin L. Sleight, MD, Lansing
Arthur A. Ulmer, MD, Grosse Pte. Shores
Richard M. Campau, Staff Assistant

COMMITTEE ON MATERNAL AND PERINATAL HEALTH

This Committee strives to improve the care of the obstetrical patient and her newborn and to provide means for physicians, nurses, and others interested in maternal and perinatal health to discuss mutual problems and share ideas. It works in close cooperation with the state agencies and medical specialty organizations.

Hermann A. Ziel, Jr., MD, Chairman, Perry
Lloyd A. Kammeraad, MD, Vice-Chairman, Grand Rapids
Silvio Aladjem, MD, Kalamazoo
Rudi Ansbacher, MD, Ann Arbor
Neil H. Aaron, U-M
Mohammed Ali Aussie, MD, Southfield
Robert J. Austin, MD, Kalamazoo
C. Arch Brown, MD, Flint
Ralph A. Cram, MD, Albion
Bruce H. Drukker, MD, East Lansing
Robert W. Dustin, MD, Dearborn
Miriam S. Daly, MD, Albion
Gerhard C. Endler, MD, Grosse Pte. Woods
Donald S. Frost, MD, Traverse City
Amy K. Gaunt, WSU
James W. Gell, MD, Bloomfield Hills
John V. Hartline, MD, Kalamazoo

Douglas G. Kinne, MD, Petoskey
Mary J. Kokosky, MD, Dearborn
James G. Kornmesser, MD, Novi
Mrs. Pat Krapohl, Jackson
Don R. Krohn, MD, Novi
Chang Y. Lee, MD, Detroit
Francis A. Locke, MD, Adrian
Robert P. Lorenz, MD, Royal Oak
Federico G. Mariona, MD, Detroit
William H. Michaels, MD, Southfield
Joseph S. Moore, MD, Grand Rapids
Wallace G. Pearson, MD, Marquette
Ronald L. Poland, MD, Detroit
Dorothy A. Porter, MD, Lathrup Village
Roger W. Postmus, MD, Ann Arbor
James W. Sharpe, MD, Port Huron
Joseph L. Sheets, MD, Lansing
Richard E. Smith, MD, Detroit
Lee B. Stevenson, MD, Southfield
Robert J. Sokol, MD, Detroit
Carolyn M. Texera, MD, East Lansing
James H. Tisdel, MD, Port Huron
Arthur A. Ulmer, MD, Grosse Pte. Shores
Kenneth J. VanderKolk, MD, Grand Rapids
Daniel J. Wilhelm, MD, Port Huron
Mason Barr, Jr., MD, Consultant, Ann Arbor
Jean Chabut, Consultant, Lansing
Harvey Day, PhD, Consultant, Lansing
Eugene V. Perrin, MD, Consultant, Detroit
George W. Russian, DO, Consultant, Okemos
Charles H. Sander, MD, Consultant, East Lansing
Kenneth Stringer, DO, Consultant, East Lansing
Richard Yerian, DO, Consultant, Lansing
Katie Brewbaker, Staff Assistant

PLANNING COMMITTEE FOR MICHIGAN CONFERENCE ON MATERNAL AND PERINATAL HEALTH

The Planning Committee, under the guidance of the MSMS Committee on Maternal and Perinatal Health, plans and implements Category I CME programs for the Annual Michigan Conference on Maternal and Perinatal Health, in cooperation with several participating organizations.

Rudi Ansbacher, MD, Co-Chairman, Ann Arbor
Robert W. Dustin, MD, Co-Chairman, Dearborn
John R. Addy, MD, Lansing
C. Arch Brown, MD, Flint
Karen Brown, RN, MS, Bay City
Mary M. Conklin, RN, Lansing
Miriam S. Daly, MD, Albion
Steven M. Donn, MD, Ann Arbor
Gregory J. Feldmeier, MD, Kalamazoo
John V. Hartline, MD, Kalamazoo
Mary J. Kokosky, MD, Dearborn
Robert P. Lorenz, MD, Royal Oak
John J. LaFerla, MD, Ann Arbor
Chang Y. Lee, MD, Detroit
Janet Malinowski, RN, Northville
Federico G. Mariona, MD, Detroit
Joseph F. Marshall, MD, Saginaw
Joseph P. Metz, MD, Flint
John G. O'Rourke, MD, Jackson
Evelyn Piehl, RN, Ann Arbor
Leonard L. Radecki, MD, Grand Rapids
Walter Schoen, MD, Ann Arbor
Mary A. Scoblic, RN, Lansing
Kenneth J. VanderKolk, MD, Grand Rapids
Hermann A. Ziel, Jr., MD, ex officio, Perry
Lloyd A. Kammeraad, MD, ex officio, Grand Rapids
Sherry L. Fent, Staff Assistant

MEDICAID LIAISON COMMITTEE

The Liaison Committee attempts to resolve individual physicians' problems with Medicaid payments and procedures, and discusses major policy issues of the Medicaid program with state government.

Allen F. Turcke, MD, Chairman, Flint
John W. Coles, MD, Mt. Pleasant
Thomas M. Flake, MD, West Bloomfield
James D. Johnston, MD, Traverse City
Cecil R. Jonas, MD, Detroit
Gary A. Krasicky, MD, Redford Twp.
Robert L. Leeser, MD, Charlotte
Thomas C. Payne, MD, Lansing
Robert H. Toteff, MD, Detroit
Kevin A. Kelly, Staff Assistant

LIAISON COMMITTEE WITH MEDICAL ASSISTANTS

The Liaison Committee advises the American Association of Medical Assistants, State of Michigan, on request, regarding medical assistant activities and problems. It also suggests projects the medical assistants may wish to undertake.

Otto H. Hahne, MD, Chairman, Warren
Cecelia F. Hissong,MD, Dearborn Heights
Joseph J. Tiziani, MD, Ann Arbor
William C. Wyte, MD, Mt. Clemens
Caroline Rich, Staff Assistant

TASK FORCE ON MEDICAL CARE COSTS

The Task Force considers and evaluates methodologies for containing the cost of quality health care, encourages cost awareness, and develops cost effectiveness information for the practicing physician. The Task Force publishes articles on cost containment in Michigan Medicine.

Richard P. Horsch, MD, Chairman, Farmington Hills
Michael G. Cotant, WSU
Everette Gustafson, MD, Pontiac
Mrs. Cathie Martin, Traverse City
James E. McGillicuddy, MD, Lansing
Scott A. Monteith, MSU
Cynthia J. Moorman, Ann Arbor
B. David Wilson, MD, Kalamazoo
John A. Richards, Staff Assistant

ADVISORY COMMITTEE TO SECTION ON MEDICAL ECONOMICS AND REIMBURSEMENT

The Advisory Committee assists the Department in setting priorities, studies current health care financing, makes specific recommendations concerning future financing mechanisms, and develops an understanding of traditional insurance companies, emerging alternative financing and health delivery systems.

Jay K. Harness, MD, Chairman, Chelsea
E. Joseph Alberding, MD, Portage
Harold A. Ballitch, II, MSU
Jack L. Barry, MD, Saginaw
Gilbert B. Bluhm, MD, West Bloomfield
Frederick B. Brown, MD, Muskegon
John B. Bryan, MD, Royal Oak
Robert B. Carbeck, MD, Ann Arbor
Frank E. Check, Jr., MD, Detroit
James D. Fryfogle, MD, Southfield
Denise G. K. Gray, MD, Detroit
Mrs. Barbara Grennan, Muskegon
Harvey W. Halberstadt, MD, Troy,
Robert H. Hamburg, MD, Detroit
Hector J. Inchaustegui, MD, Royal Oak
Margaret E. Jones, MD, East Lansing
Max L. Lichter, MD, Farmington Hills
John P. Papp, MD, Grand Rapids
Richard L. Rapport, MD, Flint
Kenneth G. Schooff, MD, Mt. Clemens
Eric L. Shampaine, U-M
Floyd S. Tukel, MD, Dearborn
Allen F. Turcke, MD, Flint
Frederick W. VanDuyne, MD, Flint
John A. Richards, Staff Assistant

COMMITTEE ON MEDICAL STAFF RELATIONS

This Committee is establishing the Hospital Medical Staff Section of the MSMS House of Delegates. It also establishes communication networks and other mechanisms for interacting with hospital medical staffs to strengthen and enhance mutual communications of MSMS and its medical staff leader members.

Gary D. Maynard, MD, Chairman, Kalamazoo
Robert D. Allaben, MD, Detroit
Robert W. Black, MD, Detroit
Henry M. Domzalski, MD, Detroit
Timothy G. Howell, MSU
James J. Humes, MD, Detroit
Devendra K. Sharma, MD, Tawas City
John C. Sullivan, MD, Port Huron
Thomas White, Staff Assistant

COMMITTEE ON MEDICAL LICENSURE AND DISCIPLINE

This Committee is to develop a new liaison with Licensing and Regulation and seek and support measures that will promote a fully effective Board of Medicine. It also submits recommendations to the MSMS Board of Directors for nominations to the Board of Medicine.

Rhoda M. Powsner, MD, Chairperson, Ypsilanti
Gilbert B. Bluhm, MD, West Bloomfield
Gerald G. Brueckner, MD, Mt. Clemens
Frederick B. Brown, MD, Muskegon
Henry A. Cartwright, MD, Detroit
Ricardo Chalela, MD, Washington
Carl A. Gagliardi, MD, Dearborn
Denise G. K. Gray, MD, Detroit
Edwin H. Gullekson, MD, Flint
Donald H. Kuiper, MD, Lansing
James A. O'Neill, MD, Clarkston
B. L. Pederson, MD, Bay City
Arthur Rose, MD, Southfield
Robert A. Teitge, MD, Warren
Luis A. Tomatis, MD, Grand Rapids
Theodore S. Vanderveen, MD, Grand Rapids
James K. Watkins, MD, Grand Rapids
Scott W. Woods, MD, Ypsilanti
Kevin A. Kelly, Staff Assistant

TASK FORCE TO REVIEW MEMBER INSURANCE BENEFIT PROGRAMS

This Task Force reviews existing and proposed insurance benefit programs for MSMS members and makes recommendations to the Board of Directors.

Jack L. Barry, MD, Chairman, Saginaw
Kenneth B. Herrington, MD, Bad Axe
James E. McGillicuddy, MD, Lansing
Robert E. Paxton, MD, Fremont
Kenneth J. Ray, MD, Trenton
B. David Wilson, MD, Kalamazoo
William B. Cheeseman, Consultant, East Lansing
Wayne E. Burmeister, Staff Assistant

COMMITTEE ON MEMBERSHIP RECRUITMENT AND RETENTION

This Committee guides all recruitment efforts aimed at non-member physicians, residents, and students. It develops membership goals, makes recommendations to the Board of Directors and conducts personal recruiting efforts when needed.

Continued on next page

COMMITTEES/Continued

Anna M. H. Broecker, MD, Chairperson, Grand Rapids
James C. Askins, MD, Jackson
June B. Asselin, MSU
Billy Ben Baumann, MD, Pontiac
Owen M. Berow, MD, Kalamazoo
Cathy O. Blight, MD, Flint
Vickers C. Hansen, MD, Manistee
Frederick E. Ludwig, II, MD, Iron River
Dorothy Kahkonen, MD, Detroit
Laurie G. McKeown, U-M
Mrs. Marcheta Morley, Ann Arbor
Mrs. Jane Mueller, Saginaw
Dolores J. Shelfoon, MD, Dearborn
Yvan J. Silva, MD, Detroit
John W. Tauscher, MD, Flint
Norman Anderson, Consultant, Flint
John C. Halstead, Consultant, Saginaw
Ms. Sue Hoeflinger, Consultant, Birmingham
Roger F. Mecum, Consultant, Detroit
Mrs. Mary Sue Meyer, Consultant, Birmingham
Wayne E. Burmeister, Staff Assistant

MICHIGAN DOCTORS POLITICAL ACTION COMMITTEE BOARD OF DIRECTORS

Thomas E. Stone, MD, Chairman, Muskegon
Larry J. Andreini, MD, Escanaba
Reuven Bar-Levav, MD, Detroit
Jack L. Barry, MD, Saginaw
Jill Berglund, Kalamazoo
Joseph J. Berke, MD, Detroit
Donald G. Blain, MD, Mt. Clemens
R. Jack Chase, MD, Grand Rapids
Lionel E. Dorfman, MD, Battle Creek
Peter A. Duhamel, MD, Rochester
John A. Feemster, MD, Detroit
Richard H. Gascoigne, MD, Adrian
Richard P. Heuschele, MD, Saginaw
William J. Jones, MD, Allen Park
William P. McCabe, MD, Grosse Pte. Woods
Susan McGillicuddy, Lansing
Robert A. Mengebier, MD, Petoskey
Fred E. Patterson, MD, Ann Arbor
Robert E. Paxton, MD, Fremont
Thomas C. Payne, MD, Lansing
Mitchell A. Rinek, MD, Lansing

LIAISON COMMITTEE WITH MICHIGAN DEPARTMENT OF PUBLIC HEALTH

The Committee works to improve information and communication channels among public health officers, practicing physicians, and the public on environmental and public health issues of mutual concern.

E. Joseph Alberding, MD, Chairman, Portage
Bradley T. Barnes, MD, Rochester
Cathy O. Blight, MD, Flint
Mrs. Evelyn Dykewicz, Flint
Douglas A. Mack, MD, Grand Rapids
David C. Nolan, MD, White Cloud
Kenneth E. Rowe, MD, Hancock
Dawn E. Springer, MD, Mason
A. Thomas Waytes, MD, Detroit
Kevin A. Kelly, Staff Assistant
Marsha M. Rohrer, MD, Lansing
Kenneth E. Rowe, MD, Calumet
Krishna K. Sawhney, MD, Taylor
Peter S. Thoms, MD, Flint
Floyd S. Tukel, MD, Dearborn
Charles H. Willison, MD, Midland
B. David Wilson, MD, Kalamazoo
Louis R. Zako, MD, Dearborn Heights
Charles R. Zimont, MD, Constantine
Kevin A. Kelly, Staff Assistant

MICHIGAN STATE MEDICAL SOCIETY/MICHIGAN HOSPITAL ASSOCIATION LIAISON COMMITTEE

This formal Liaison Committee is composed of designated leaders of the two organizations. The Liaison Committee does not make policy for either organization; each organization refers any recommendations to the MSMS Board of Directors or MHA Board of Trustees for approval.

Thomas R. Berglund, MD, Portage
Donald K. Crandall, MD, Muskegon
Richard J. McMurray, MD, Flint
Louis R. Zako, MD, Dearborn Heights
Bruce W. Ambrose, East Lansing
William E. Madigan, East Lansing

COMMITTEE ON MSMS POLICY MANUAL

This Committee reviews actions of the House of Delegates and incorporates any policy decisions into the Policy Manual of MSMS.

Robert D. Burton, MD, Chairman, Grand Rapids
Frederick W. Bryant, MD, Royal Oak
Leland E. Holly, II, MD, Muskegon
Richard L. Rapport, MD, Flint
Kenneth J. Ray, MD, Trenton
Vada L. Davis, Staff Assistant

BOARD OF DIRECTORS, PHYSICIAN SERVICE GROUP, INC.

Leland E. Holly, II, MD, Chairman, Muskegon
Frederick W. Bryant, MD, Royal Oak
Mark Campbell, MD, Grand Rapids
Bruce Drukker, MD, East Lansing
Elizabeth A. Hutchinson, MD, Lansing
Allen F. Turcke, MD, Flint
Bruce W. Ambrose, PSG Executive Vice-President, East Lansing
Warren F. Tryloff, Consultant, East Lansing
Vada L. Davis, Staff Assistant

COMMITTEE ON PUBLIC SERVICE

This Committee develops and oversees all public relations and public information activities. It provides physician input to the program suggestions and activities advanced by outside consultants and MSMS staff.

Richard H. Gascoigne, MD, Chairman, Adrian
Susan E. Adelman, MD, Detroit
Mark G. Campbell, MD, Grand Rapids
Mrs. Nancy Crandall, Muskegon
Robert L. Cross, MD, Flushing
Clyde R. Flory, Jr., MD, Lansing
John M. Hilu, WSU
Michael Ingram, MSU
C. Thomas Kelso, MD, Spring Lake
Robert J. Kobs, MD, Jackson
Frederick J. Margolis, MD, Kalamazoo
James H. Park, MD, Owosso
Fred E. Patterson, MD, Jackson
Thomas C. Payne, MD, Lansing
M. Gary Robertson, MD, Grand Haven
Robert M. Williams, MD, Petoskey
Linda L. Martin, Consultant, Lansing
Sherry N. Wellman, Staff Assistant

TASK FORCE ON PROFESSIONAL LIABILITY

The Task Force reviews the professional liability climate in Michigan and the nation, becomes familiar with the professional liability terms and legislation, and recommends any appropriate legislation or alternative mechanisms to be used in Michigan.

Frederick V. Minkow, MD, Chairman, Bloomfield Hills
Billy Ben Baumann, MD, Pontiac
Peter Kowynia, WSU
Thomas C. Payne, MD, Lansing
Mrs. Suzie Pederson, Bay City
Rhoda M. Powsner, MD, Ypsilanti

Kenneth J. Ray, MD, Trenton
James A. Read, MD, Birmingham
John L. Shek, MD, Saginaw
Donald N. Sweeny, MD, St. Clair Shores
Lisa L. VonMoltke, MSU
William B. Cheeseman, Consultant, East Lansing
Richard Campau, Staff Assistant

COMMITTEE ON PUBLICATIONS

This Committee serves as an advisory board to the editors in determining policy, setting new directions, suggesting subject material, overseeing finances, and reviewing all display advertising for MSMS publications.

Harvey M. Andre, MD, Chairman, Grand Rapids
Frederick W. Bryant, MD, Royal Oak
Vickers C. Hansen, MD, Manistee
Leland E. Holly, II, MD, Muskegon
Richard L. Rapport, MD, Flint
Marguerite Shearer, MD, Dexter
Louis R. Zako, MD, Dearborn Heights
Judy E. Marr, Staff Assistant

COMMITTEE ON RISK MANAGEMENT PROGRAM

This Committee aids in the development of any risk management program or courses which MSMS decides to offer to its members through its own resources or those of the Physician Service Group, Inc.

Louis R. Zako, MD, Chairman, Dearborn Heights
Leland E. Holly, II, MD, Muskegon
W. Peter McCabe, MD, Grosse Pte. Woods
Marguerite Shearer, MD, Dexter
Robert M. Leitch, MD, Battle Creek
J. Douglas Peters, Consultant, Detroit
Richard Campau, Staff Assistant

COMMITTEE OF SPECIALTY SOCIETY PRESIDENTS

This Committee provides for rapid communication between MSMS and the members of specialty organizations. It deals with any subject of mutual concern except scientific or clinical medicine.

Richard O. McMurray, MD, Chairman, Flint
Michigan Allergy Society: Allen Sosin, MD, Farmington
Michigan Society of Anesthesiologists: Gary D. Maynard, MD, Kalamazoo
Michigan Chapter, American College of Chest Physicians: Samuel M. McMahon, MD, Lansing
Michigan Section on Clinical Pharmacology and Therapeutics: George L. Royer, Jr., MD, Kalamazoo
Michigan Society of Colon and Rectal Surgeons: Steven N. Klein, MD, Southfield
Michigan Dermatological Society: Margaret C. Douglass, MD, Detroit
Michigan Chapter, American College of Emergency Physicians: Robert D. Aranosian, DO, East Lansing
Michigan Academy of Family Physicians: C. Edward Cotton, MD, Marcellus
Michigan Society of Gastrointestinal Endoscopy: Ramon R. Joseph, MD, Eloise
Michigan Society of General Surgeons: Donald C. Camp, MD, Niles
Michigan Health Officers Association: John B. Atwater, MD, Ann Arbor
Michigan Society of Internal Medicine: John P. Papp, MD, Grand Rapids
Michigan Neurological Society: Raymond B. Bauer, MD, Detroit
Michigan Association of Neurological Surgeons: Robert E. M. Ho, MD, Troy
Michigan College of Nuclear Medicine Physicians: John E. Freitas, MD, Royal Oak
Michigan Section, American College of Obstetricians and Gynecologists: Lloyd A. Kammeraad, MD, Grand Rapids
Michigan Occupational Medical Association: Jack E. Benkert, MD, Grand Blanc
Michigan Ophthalmological Society: Raymond R. Margherio, MD, Royal Oak
Michigan Orthopaedic Society: Russell M. Cashen, MD, Kalamazoo
Michigan Oto-Laryngological Society: Sean B. Peppard, MD, Detroit
Michigan Society of Pathologists: Billy B. Baumann, MD, Pontiac
Michigan Chapter, American Academy of Pediatrics: Natalia M. Tanner, MD, Detroit
Michigan Academy of Physical Medicine and Rehabilitation: Robert L. Joynt, MD, Detroit
Michigan Chapter, American College of Physicians: Arnold R. Axelrod, MD, Detroit
Michigan Academy of Plastic Surgeons: William D. Simpson, MD, Grand Rapids
Michigan Psychiatric Society: Melvin Bornstein, MD, Birmingham
Michigan Psychoanalytic Society: Ronald M. Benson, MD, Ann Arbor
Michigan Radiological Society: Robert S. Ormond, MD, Flint
Michigan Rheumatism Society: Jose Granda, MD, Detroit
Michigan Chapter, American College of Surgeons: James C. Stanley, MD, Ann Arbor
Michigan Society of Therapeutic Radiologists: Donald P. Stratton, MD, Muskegon
Michigan Society of Thoracic Surgeons: Joseph Lewis, MD, Detroit
Michigan Branch, American Urological Association: Robert H. Moyad, MD, Ann Arbor
Sherry N. Wellman, Staff Assistant

AD HOC COMMITTEE ON RECOGNITION OF SPECIALTY SOCIETIES BY HOUSE OF DELEGATES

Frank B. Walker, MD, Chairman, Grosse Pte. Farms
William B. Jensen, MD, Grand Rapids
James E. McGillicuddy, MD, Lansing
Vada L. Davis, Staff Assistant

COMMITTEE ON SPORTS MEDICINE

This Committee sponsors conferences aimed at physicians and others with an interest in sports medicine. It also provides sports medicine information and medical evaluation of sports rules when requested by the Michigan High School Athletic Association, Inc.

Charles R. Zimont, MD, Chairman, Constantine
Mrs. Karen Askins, Jackson
Roy T. Bergman, MD, Escanaba
Edward M. Fugate, MD, Muskegon
Perry W. Greene, Jr., MD, Grand Rapids
R. Scott Herron, MSU
Leonard J. Kibileski, WSU
Richard A. Lemmer, MD, Kalamazoo
Robert A. Lewis, MD, Kalamazoo
Robert J. Murray, MD, Trenton
Robert C. Nestor, DO, Bloomfield Hills
Gerald A. O'Connor, MD, Ann Arbor
William B. Redmon, MD, Midland
Russell Miller, Consultant, Ann Arbor
Vern L. Norris, Consultant, East Lansing
Sherry L. Fent, Staff Assistant

COMMITTEE ON WAYS AND MEANS

This Committee furnishes cost estimates to the House of Delegates on all resolutions requiring expenditure of funds. It also reviews general fiscal policies of the Society on behalf of the House of Delegates.

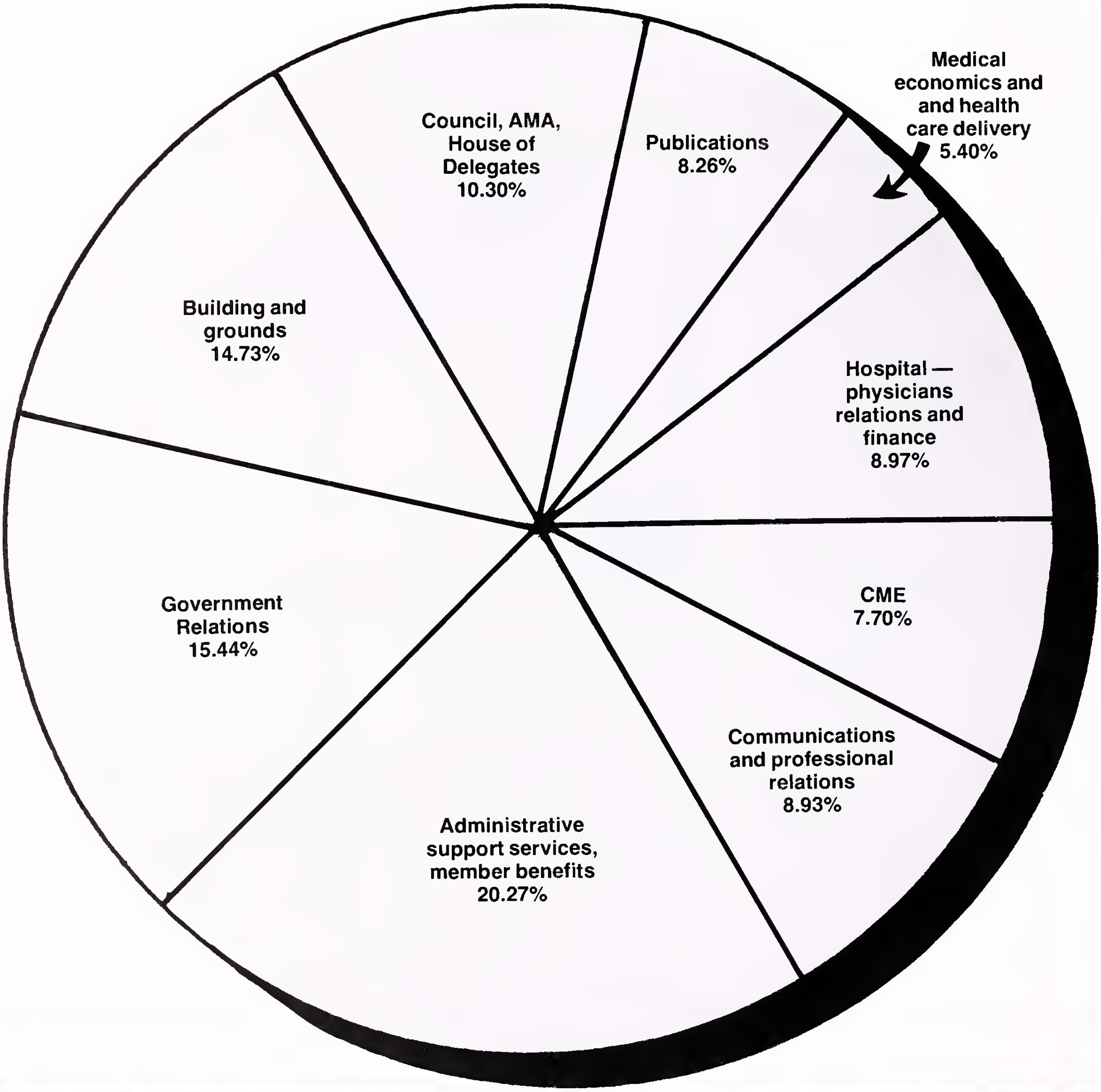
Richard J. McMurray, MD, Chairman, Flint
Thomas C. Blair, MD, Lansing
Arnold L. Brown, MD, Pontiac
R. Jack Chase, MD, Grand Rapids
Charles Siefert, MD, Battle Creek
Fred W. Whitehouse, MD, Detroit
Leonard H. Wolin, MD, Ann Arbor
Richard M. Campau, Staff Assistant ☐

Where your dues go

Membership fees for your state medical society, which are $290 for 1985, are parceled out prior to the MSMS fiscal year which begins December 1. Making the decisions are members of the Finance Committee of the MSMS 1985 Board of Directors, chaired by Robert Paxton, MD, Fremont.

The Finance Committee acts on the recommendations of the MSMS Budget Subcommittee to the Finance Committee and spends many hours during the fall months analyzing every projected expense and revenue item. They obtain final approval for the budget from the MSMS Board of Directors.

The pie chart below illustrates the distribution of MSMS income from dues and other sources to MSMS program areas. It is published to give MSMS members a clearer idea of how MSMS revenues are spent.



The AMA puts current information at your fingertips.

The first nationwide medical information network brings a new dimension to the way in which physicians and other health care professionals keep abreast of the latest knowledge in their profession.

Now, through the use of a low-cost computer terminal or personal computer, you can have instant access to authoritative and up-to-date information. The American Medical Association's computerized data bases place a wide range of professional resources at your fingertips, such as clinical, administrative, medical practice information, and abstracts of current clinical literature. Physicians can earn Category I, Continuing Medical Education (CME) credit using the Massachusetts General Hospital Continuing Medical Education programs or can elect to use the MGH-CME programs as informational updates or refresher courses.

Adding a new dimension to the way in which you communicate is MED/MAIL electronic mail. With the same terminal, you can send messages to your colleagues across the country or across the city . . . in minutes.

Information that could take hours to acquire through traditional channels can now be gathered in minutes, giving you valuable extra time for other important activities. And you can use the medical information network at your convenience, 24 hours a day, from your office, hospital or home.

It's surprisingly economical and professionally indispensable.

GTE Telenet

Medical Information Network

GTE

FOR SUBSCRIPTION INFORMATION PLEASE CONTACT

PHYSICIAN SERVICE GROUP, INC.
A member service subsidiary of the
MICHIGAN STATE MEDICAL SOCIETY
EAST LANSING, MICHIGAN

Ellen Vinocur Potash
Telephone 517/337-1351

By Nancy Crandall

Six good reasons to join MSMS/A

Membership in the Michigan State Medical Society Auxiliary is somewhat like voting in the November election - the opportunity is there but too many who are eligible don't bother to share in the responsibility. There are 20,693 licensed physicians in Michigan and 2,396 members of MSMS Auxiliary. Clearly the members of our organization need to communicate more effectively the benefits derived from belonging. The benefits are many, including the fellowship and support we share with one another. The Auxiliary strives to promote friendships among physicians' families as well as support of physicians' spouses who face emotional, marital, and personal situations familiar to medical families.

Benefits are derived for medicine as a whole through various MSMS Auxiliary activities. In these times of increased government intervention into the practice of medicine, the Auxiliary is in the forefront in providing current information to its members. Physicians' spouses are kept informed on legislative issues and have access to a variety of educational meetings and material regarding the policical process, pending legislation, and networking to share this information.

Generous supporter

As the cost of medical education continues to rise, the Auxiliary has responded by being a generous supporter of the AMA Education and Research Foundation. Through a variety of imaginative fundraising efforts, Auxilians and their spouses have contributed thousands of dollars in unrestricted funds to approved medical schools. The dollars help fill in the gaps where government grants and university budgets fail.

Auxiliary membership provides opportunities for volunteer service in communities throughout the state. Each county auxiliary determines its own community's needs and how it can best address them. The state auxiliary provides assistance, speakers, and resources such as pamphlets, films and other information when possible. MSMSA has worked with other groups on such projects as medicare information seminars, child passenger safety, organ donor awareness, fetal alcohol syndrome, and child abuse prevention. The organization also promotes programs dealing with physical fitness, immunization, highway safety, and physician impairment. International efforts include the collection of pharmaceuticals and medical equipment for World Medical Relief which distributes the items to needy people throughout the world. The Auxiliary contacts all members within the state through meetings, the quarterly publication *Auxilium*, and educational materials, and MSMS/A provides leadership training and opportunities for participation at all levels.

Partners and promoters

As MSMSA increases its responsibilities as a partner of the Michigan State Medical Society, it also must increase its service efforts to the medical profession. Members must become better educated about the issues facing medicine today and become promoters of the medical profession through our activities. The Auxiliary asks for a very small percentage of time from members' very busy lives to accomplish these goals.

To paraphrase an AMA Auxiliary membership brochure; there are six good reasons why you should be a member of the MSMS Auxiliary:

- You will have a voice in one of the most constructively involved health organizations in the country;
- You will have opportunities to impact legislation affecting health care and medical practice;
- You will receive personal benefits through leadership training, educational seminars, informational meetings;
- You will receive the national magazine and newsletter, *FACETS*, written for and about physician spouses; publications to keep you up-to-date on pertinent issues; and informational materials covering various health topics;
- You will have the opportunity to be involved in your community, with your neighbors, extending the work of physicians where it is needed to help keep people healthy;
- You will be part of a network of 81,000 physicians' spouses united by a common bond for a common goal: to improve the health and quality of life for all people. ☐

Mrs. Crandall, Muskegon, is MSMS/A president.

Motrin reduces inflammation, pain ...and price

New low price...major savings

The dramatic reduction in the price of *Motrin* Tablets means substantial savings from now on for your patients and for patients all across the country for whom *Motrin* Tablets are prescribed.

Motrin is priced lower than Clinoril, Feldene, or Naprosyn.

The price of *Motrin* Tablets to pharmacies has been reduced as much as 35%. Patients taking the average dosage should now pay less for therapy with *Motrin* Tablets than for almost any other nonsteroidal anti-inflammatory drug you prescribe...less, for example, than for Clinoril, Feldene, or Naprosyn. And, of course, all strengths of *Motrin* Tablets continue to be available by prescription only.

Please turn the page for a brief summary of prescribing information.

Motrin® 400 & 600 mg TABLETS
ibuprofen

Good medicine...good value

© 1984 The Upjohn Company

The Upjohn Company **Upjohn** Kalamazoo, Michigan 49001

Motrin® Tablets (ibuprofen)

Contraindications: Anaphylactoid reactions have occurred in individuals hypersensitive to *Motrin* Tablets or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin, iodides, or other nonsteroidal anti-inflammatory agents.

Warnings: Peptic ulceration and GI bleeding, sometimes severe, have been reported. Ulceration, perforation and bleeding may end fatally. An association has not been established. Use *Motrin* Tablets under close supervision in patients with a history of upper gastrointestinal tract disease, after consulting ADVERSE REACTIONS. In patients with active peptic ulcer and active rheumatoid arthritis, try nonulcerogenic drugs, such as gold. If *Motrin* Tablets are used, observe the patient closely for signs of ulcer perforation or GI bleeding.

Chronic studies in rats and monkeys have shown mild renal toxicity with papillary edema and necrosis. Renal papillary necrosis has rarely been shown in humans treated with *Motrin* Tablets.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue *Motrin* Tablets and the patient should have an ophthalmologic examination, including central visual fields and color vision testing.

Fluid retention and edema have been associated with *Motrin* Tablets; use with caution in patients with a history of cardiac decompensation or hypertension. In patients with renal impairment, reduced dosage may be necessary. Prospective studies of *Motrin* Tablets safety in patients with chronic renal failure have not been done.

Motrin Tablets can inhibit **platelet aggregation** and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and on anticoagulant therapy.

Patients should report signs or symptoms of **gastrointestinal ulceration** or bleeding, skin rash, weight gain, or edema.

Patients on prolonged **corticosteroid therapy** should have therapy tapered slowly when *Motrin* Tablets are added.

The antipyretic, anti-inflammatory activity of *Motrin* Tablets may mask inflammation and fever.

As with other nonsteroidal anti-inflammatory drugs, borderline elevations of liver tests may occur in up to 15% of patients. These abnormalities may progress, may remain essentially unchanged, or may be transient with continued therapy. Meaningful elevations of SGPT or SGOT (AST) occurred in controlled clinical trials in less than 1% of patients. Severe hepatic reactions, including jaundice and cases of fatal hepatitis, have been reported with ibuprofen as with other nonsteroidal anti-inflammatory drugs. If liver disease develops or if systemic manifestations occur (e.g. eosinophilia, rash, etc.), *Motrin* should be discontinued.

Drug interactions. *Aspirin:* used concomitantly may decrease *Motrin* blood levels.

Coumarin: bleeding has been reported in patients taking *Motrin* and coumarin.

Pregnancy and nursing mothers: *Motrin* should not be taken during pregnancy or by nursing mothers.

Adverse Reactions: The most frequent type of adverse reaction occurring with *Motrin* is gastrointestinal of which one or more occurred in 4% to 16% of the patients.

Incidence Greater than 1% (but less than 3%)—Probable Causal Relationship

Gastrointestinal: Nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence); **Central Nervous System:** Dizziness,* headache, nervousness; **Dermatologic:** Rash* (including maculopapular type), pruritus; **Special Senses:** Tinnitus; **Metabolic/Endocrine:** Decreased appetite; **Cardiovascular:** Edema, fluid retention (generally responds promptly to drug discontinuation; see PRECAUTIONS).

Incidence less than 1%—Probable Causal Relationship**

Gastrointestinal: Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, melena, gastritis, hepatitis, jaundice, abnormal liver function tests; **Central Nervous System:** Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma; **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia; **Special Senses:** Hearing loss, amblyopia (blurred and/or diminished vision, scotomata, and/or changes in color vision) (see PRECAUTIONS); **Hematologic:** Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit; **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations; **Allergic:** Syndrome of abdominal pain, fever, chills, nausea and vomiting; anaphylaxis; bronchospasm (see CONTRAINDICATIONS); **Renal:** Acute renal failure in patients with pre-existing significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria; **Miscellaneous:** Dry eyes and mouth, gingival ulcer, rhinitis.

Incidence less than 1%—Causal Relationship Unknown**

Gastrointestinal: Pancreatitis; **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri; **Dermatologic:** Toxic epidermal necrolysis, photoallergic skin reactions; **Special Senses:** Conjunctivitis, diplopia, optic neuritis; **Hematologic:** Bleeding episodes (e.g., epistaxis, menorrhagia); **Metabolic/Endocrine:** Gynecomastia, hypoglycemic reaction; **Cardiovascular:** Arrhythmias (sinus tachycardia, sinus bradycardia); **Allergic:** Serum sickness, lupus erythematosus syndrome, Henoch-Schonlein vasculitis; **Renal:** Renal papillary necrosis.

*Reactions occurring in 3% to 9% of patients treated with *Motrin*. (Those reactions occurring in less than 3% of the patients are unmarked.)

**Reactions are classified under "*Probable Causal Relationship (PCR)*" if there has been one positive rechallenge or if three or more cases occur which might be causally related. Reactions are classified under "*Causal Relationship Unknown*" if seven or more events have been reported but the criteria for PCR have not been met.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine so alkaline diuresis may be beneficial.

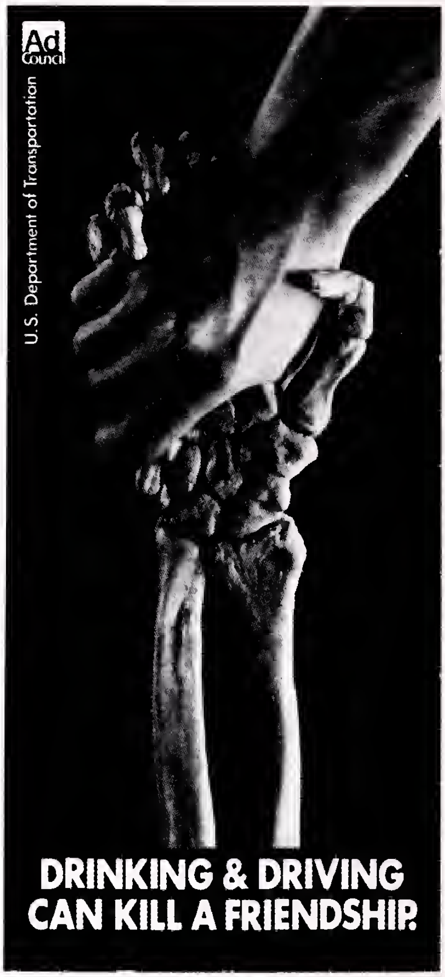
Dosage and Administration: Rheumatoid arthritis and osteoarthritis. Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Do not exceed 2400 mg per day. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary.

Caution: Federal law prohibits dispensing without prescription. MED B-7-S

Motrin is a registered trademark of The Upjohn Manufacturing Company

Upjohn The Upjohn Company
Kalamazoo, Michigan 49001

J-4791 August, 1984


Ad Council
U.S. Department of Transportation
DRINKING & DRIVING CAN KILL A FRIENDSHIP.

Ad Council A Public Service of This Publication.
©1984 The Advertising Council, Inc.

United Way
I Care!

BUILD A BETTER COMMUNITY WITH YOUR BARE HANDS.

When you give to United Way, your money works for you at home. It goes into community services for the elderly, local youth programs and foster care.

It also helps you run blood banks and facilities for the physically handicapped.

In fact, your donation helps provide literally hundreds of services that make life a lot better for people in your town.

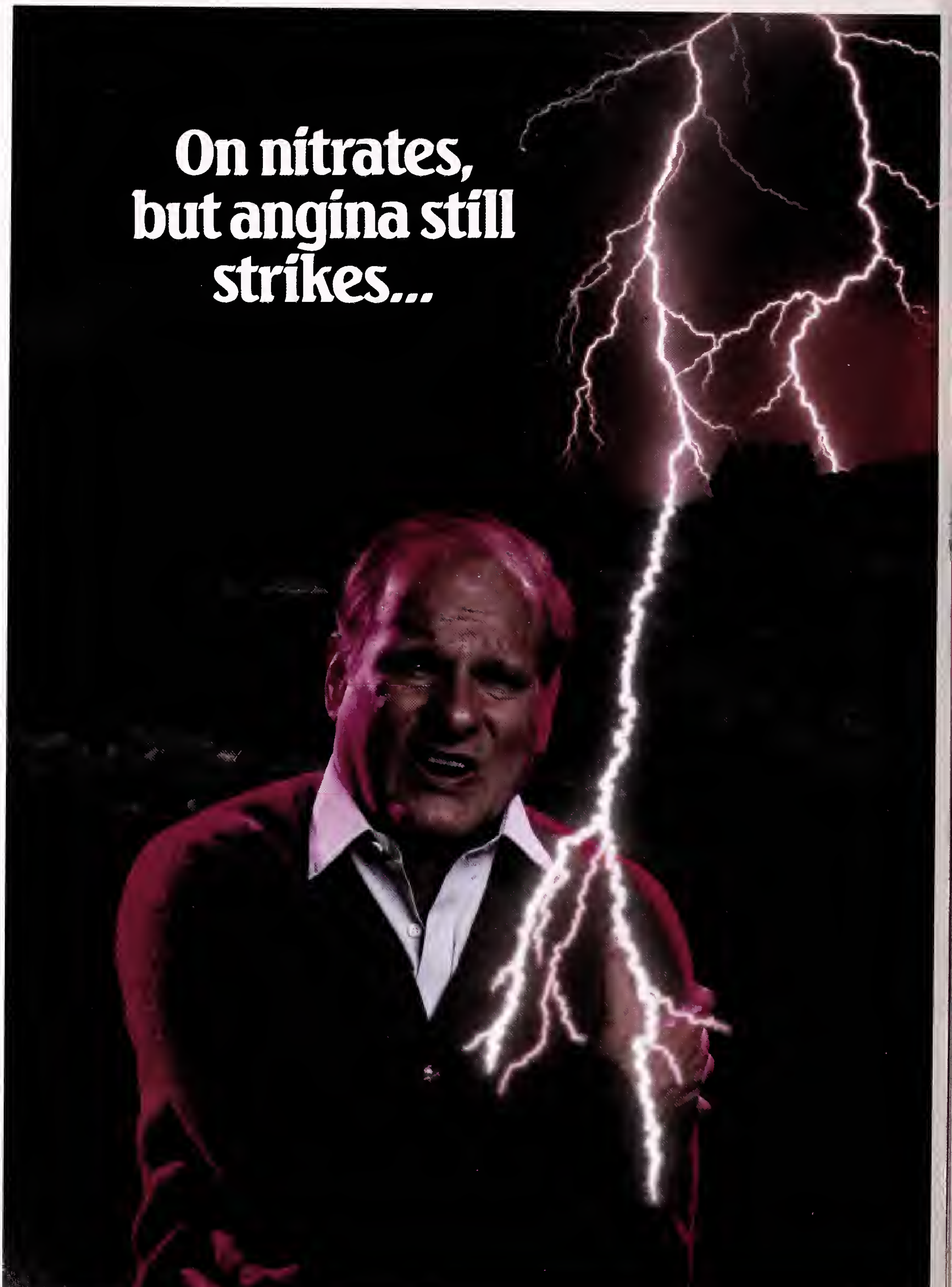
So when your United Way volunteer comes around, be generous.

A better community is in your hands.

United Way
THANKS TO YOU IT WORKS
FOR ALL OF US.

A PUBLIC SERVICE
OF THIS PUBLICATION &
THE ADVERTISING COUNCIL
Ad Council

© United Way 1984


On nitrates,
but angina still
strikes...

After a nitrate, add ISOPTIN®

(verapamil HCl/Knoll)

To protect your patients, as well as their quality of life, add Isoptin instead of a beta blocker.

First, Isoptin not only reduces myocardial oxygen demand by reducing peripheral resistance, but also increases coronary perfusion by preventing coronary vasospasm and dilating coronary arteries — both normal and stenotic. These are antianginal actions that no beta blocker can provide.

Second, Isoptin spares patients the beta-blocker side effects that may compromise the quality of life.

With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin... for more comprehensive antianginal protection without side effects which may cramp an active life style.

ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page.

ISOPTIN® TABLETS

(verapamil HCl/Knoll)

80 mg and 120 mg

Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction <30%) or moderate to severe symptoms of cardiac failure. Control milder heart failure with optimum digitalization and/or diuretics before ISOPTIN is used. ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild, and controlled by decrease in ISOPTIN dose). Occasional elevations of liver enzymes have been reported; patients receiving ISOPTIN should have liver enzymes monitored periodically. Patients with atrial flutter/fibrillation and an accessory AV pathway (e.g., W-P-W or L-G-L syndromes) may develop a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion. AV block may occur (3rd degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema, and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with ISOPTIN. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, patients should be monitored closely. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function or in patients who have also recently received methyldopa. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patient carefully monitored. ISOPTIN may have an additive hypotensive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR<50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%). The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: confusion, paresthesia, insomnia, somnolence, equilibrium disorders, blurred vision, syncope, muscle cramps, shakiness, claudication, hair loss, maculae, and spotty menstruation. Overall continuation rate of 94.5% in 1,166 patients. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in 80 mg and 120 mg sugar-coated tablets. July 1982 2068

KNOLL PHARMACEUTICAL COMPANY
knoll® 30 NORTH JEFFERSON ROAD, WHIPPANY, NEW JERSEY 07981

2195

TRUTH

When the North Atlantic Treaty Organization was formed in 1949, it was formed for one reason. To stop Soviet aggression in Europe.

TRUTH

The Warsaw Pact's conventional fighting capabilities far exceed that of European NATO forces.

TRUTH

In order to maintain peace and freedom in Europe, NATO has effectively maintained a policy of deterrence with the Soviet Union.

TRUTH

The past 35 years of peace have been one of the longest periods of European peace in recorded history.

TRUTH

The Soviets will not risk war. Unless they are sure they can win.

NATO.

**We need your support.
And the truth is, you need ours.**

Ad Council *A public service message from this magazine and the Advertising Council.*

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Lydia Baltarowich, MD — EM
2799 West Grand Blvd.
Detroit 48202

Stanley L. Barton, MD — OPH
2177 Fourth Street
Trenton, 48183

Terry L. Baxter, MD — IM
2021 Rambling Rd.
Kalamazoo 49008

Marcus G. Beversluis, MD — IM
2727 DeHoop Ave., SW
Grand Rapids 49509

C.B. Bhabuwala, MD — U
4707 St. Antoine-1 South
Detroit 48201

Lia C. Boyanton, MD — FP
180 Leslie Lane-Apt. #245
Pontiac 48054

Walter J. Boyanton, MD — FP
180 Leslie Lane-Apt. #245
Pontiac 48054

George W. Chambers, MD — IM
15445 Prest
Detroit 48227

J. Chandrasekhar, MD — PD/N
6767 West Outer Drive
Detroit 48235

Kalpana A. Choksi, MD — PD
18600 Van Horn
Woodhaven 48193

Nancy Couch, MD — IM
3379 Edwin #2
Detroit 48212

Byeong G. Chun, MD — GP
11538 Martin Rd. #1
Warren 48093

Sally J. Cullen, MD — PD
16800 W. 12 Mile Rd.
Southfield 48076

Robert G. Drake, MD — P
2200 Fuller Road-B Ste. 1104
Ann Arbor 48105

Filipinas C. Durano, MD — GP
1107 Riverview St.
Rogers City 49770

Roger Edvenson, MD — OBG
1900 Wealthy St., SE #330
Grand Rapids 49506

Lawrence Eilender, MD — N/IM
14800 West McNichols Road #408
Detroit 48235

Alan J. Elnick, MD — GP
100 Fitzgerald St.
Bay City 48706

Marilee H. Frazer, MD — PTH
400 E. Lafayette
Detroit 48226

Sun O. Gim, MD — TR
Oakwood Hospital
Dearborn 48124

Gary M. Goodman, MD — PD
614 Second
Ann Arbor 48103

Bryan R. Grieme, MD — R
21350 Carlysle
Dearborn 48124

Georges K. Haddad, MD — CD/GS
3562 Historic
Dearborn 48124

Steven P. Hadesman, MD — IM
987 E. Jefferson
Detroit 48207

Marilyn T. Haupt, MD — IM
4201 St. Antoine
Detroit 48201

Gilbert E. Herman, MD — PTH
4234 Hampton
Royal Oak 48073

Nancy Ann Hurchik-Munaco, MD — FP
23800 Orchard Lake Rd.
Farmington Hills 48024

Eve Inchardi, MD — IM
6356 Village Green Circle #8
Portage 49002

Daniel S. Johnson, MD — GS
621 John St.
Kalamazoo 49007

Peter P. Karpawich, MD — PD
926 East Lafayette #301
Detroit 48207

Michael S. Kennedy, MD — ORS
5793 W. Johnson Rd. Box 708
Ludington 49431

Lawrence Y. Kim, MD — P
24555 Haig
Taylor, 48180

Steven W. Kowalsky MD — U
14801 Southfield
Allen Park, 48101

Charles R. Lee, DO — AN
900 Woodward Ave.
Pontiac 48053

Edward B. Lewin, MD — PD
Henry Ford Hosp. Dept./Ped.
Detroit 48202

Jeffrey Lipkowitz, MD — OPH
1000 Wall St.
Ann Arbor 48105

Christopher Lui, MD — AN
74 Carlyle Ave.
Coldwater 49036

Mary Martinen, MD — IM
1321 Orleans #1404W
Detroit 48202

Dennis E. Means, MD — OBG
2900 South Fort Street
Detroit 48217

Lylas G. Mogk, MD — OPH
1315 Grayton
Grosse Pte. 48230

William K. Nasso, MD — IM
1300 E. Lafayette #2411
Detroit 48207

Robert M. Nelson, MD — GS
4201 St. Antoine
Detroit 48201

Timothy A. Nelson, MD — IM/CD
1900 Wealthy St., SE #390
Grand Rapids 49506

Bonnie Jean Nowaczyk, MD — IM
3779 Sunset Dr.
Flint 48503

Talmage J. Raine, MD — D
4201 St. Antoine
Detroit 48201

Jehangir N. Rao, MD — IM/GE
1770 Palmetto Ct.
Bloomfield Hills 48013

Tummal M. Rao, MD — DR
One Hurley Plaza
Flint 48502 ☐

Angina Protection with Benefits for a Lifetime

ONCE-DAILY CONTROL WITH HEART-SAVING BENEFITS

By reducing heart rate and cardiac contractility, INDERAL LA helps protect the heart from the potentially serious and debilitating consequences of ischemia. A highly effective antianginal agent for around-the-clock control of symptoms, INDERAL LA also provides cardiovascular protection for a sense of security in the years ahead.

PROTECTION AND EXPERIENCE NO CALCIUM BLOCKER CAN MATCH

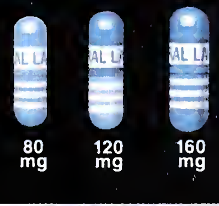
Unlike calcium blockers, INDERAL LA—either alone or with a nitrate—is recommended for early treatment of angina in the majority of patients. Equally important, INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use.

START WITH 80 MG ONCE DAILY

Dosage may be increased to 160 mg once daily, as needed, to achieve optimal control. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY **INDERAL® LA**

(PROPRANOLOL HCl) *LONG ACTING CAPSULES*



Ayerst

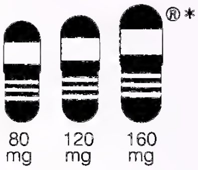
The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories

JUST ONCE EACH DAY FOR SIMPLIFIED CORE THERAPY IN ANGINA

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



Just once each day...

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

> IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

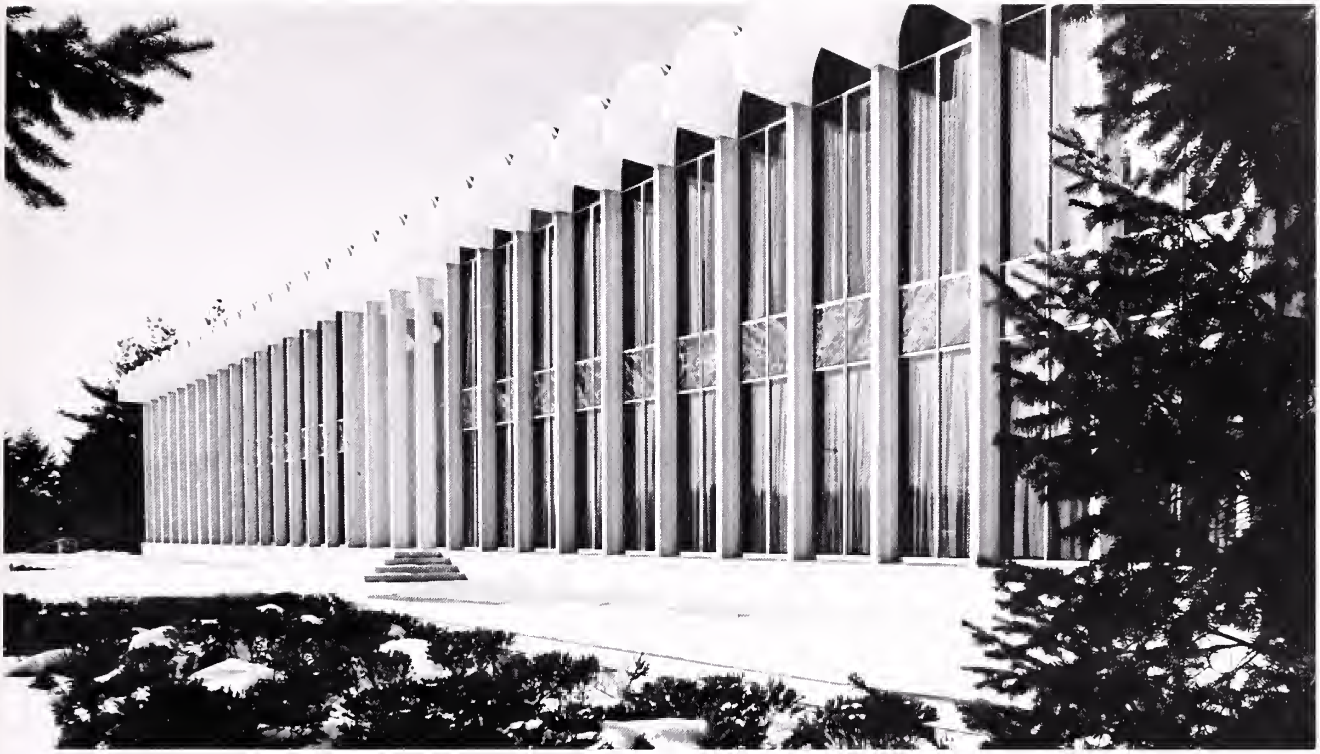
HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

8833/384

Ayerst®
AYERST LABORATORIES
New York, N.Y. 10017



MSMS, MSMS/A, AMA & MEDICAL ASSISTANTS

January 9 — Committee on Concerns of Women Physicians, MSMS Headquarters, East Lansing, contact: Linda Munson, MSMS headquarters.

January 16 — MSMS Board, MSMS headquarters, contact: Bruce Ambrose, MSMS director.

January 23 — Committee on Maternal and Perinatal Health, MSMS headquarters, contact: Katie Brewbaker, MSMS headquarters.

February 4 (Feb. 11 Snow Day) — MSMS Auxiliary Board Meeting, MSMS Building, East Lansing, contact: Vi Heins, MSMS headquarters.

February 8-10 — Medical Assistants Midwinter Seminar, Midway Motor Lodge, Warren, contact: Caroline Rich, MSMS headquarters.

February 14-16 — National Leadership Conference, Palmer House, Chicago, contact: American Medical Association, 535 N. Dearborn St., Chicago, 60610 (312) 645-5000.

February 19, 20, 21 — AMA Auxiliary National Cluster Meeting, Drake Hotel, Chicago, contact: Vi Heins, MSMS headquarters.

February 21, 22, 23 — AMA Leadership Conference, Marriott Hotel, Chicago, contact: Vi Heins, MSMS heaquarters.

March 6 — MSMS Board, MSMS headquarters, contact: Bruce Ambrose, MSMS director.

March 11 — MSMS Hospital Medical Staff Section, Michigan Inn, Southfield, contact: Thomas E. White, MSMS headquarters.

March 12 — Legislative Day, MSMS Auxiliary, Civic Center, Lansing, contact: Vi Heins, MSMS headquarters.

March 28-29 — Michigan Conference on Maternal and Perinatal Health, Hyatt Regency Dearborn, contact: Sherry Fent, MSMS headquarters.

April 26-28 — 1985 MSMS House of Delegates meeting, Michigan Inn, Southfield, contact: Richard Campau, MSMS headquarters.

April 29 — MSMSA Mini-Conference for County Officers, MSMS Headquarters, East Lansing, contact: Vi Heins, MSMS headquarters.

May 6, 7, 8 — 59th Annual Session, MSMS Auxiliary, Holiday Inn, Muskegon, contact: Vi Heins, MSMS headquarters.

June 16-20 — Annual AMA House of Delegates, Chicago, contact: Bruce Ambrose, MSMS headquarters.

July 18-21 — Midsummer Meeting, MSMS Board of Directors, Hilton Shanty Creek, Belaire, contact: Bruce Ambrose, MSMS director.

OTHER MEETINGS

May 15, 1985 — Executive Committee Meeting, Michigan Allergy Society, University of Michigan, contact: David Seaman, MD, Secretary, Michigan Allergy Society, 8578 Canton Center Road, Canton 48187 (313) 453-2661.

By Judith Marr
Editor

Physician Service Group, Inc. offers solutions to practice problems and more

PRE REC
ON
STAFF

Ellen Vinocur Potash, GTE/MINET Project Manager with Physician Service Group, Inc. demonstrates the electronic communication and information system for Louis E. Heideman, MD, Birmingham.

There are many products and services on the market which can help the physician run a medical practice more smoothly and efficiently.

But how does the physician distinguish which are readily available, economical and of good quality?

That is where the MSMS Physician Service Group, Inc., comes in. The PSG's objective is to provide services to Michigan physicians and help to increase their economic well being both in business and personal life.

Another PSG objective is to aid the physician by making available tools and resources of reasonable cost and constant quality.

Services available

Here are some of the services provided:

(1) Practice management consultations and seminars. Seminars are offered to residents about to establish themselves in practice and for physicians who have been serving patients for years.

(2) Bill collecting services. The PSG endorses I.C. System, Inc. for use by physicians in collecting indebted accounts. Since the PSG endorsed IC System in 1980, the company has collected more than $6,000,000 for Michigan physicians. Currently, more than 2,000 physicians take advantage

of this program, at a cost substantially below other collection companies' charges.

(3) Credit card service. The MSMS/PSG Credit Card Program has 391 MSMS members enrolled, allowing patients to pay bills by credit card. PSG collects the payments and every two weeks sends the physician a check for the appropriate amount, less a small administrative charge. This system reduces the physicians' costs in sending out statements and in office collection efforts.

(4) Administrative services. The PSG provides executive/secretarial/management services for several Michigan specialty societies and health care professionals' organizations. This includes member records, arrangements of major meetings, staffing for committee and general membership meetings, newsletter services, dues billing and collection. Contact Caroline Rich or Viola M. Heins at (517) 337-1351 for details.

Quality sources

The MSMS Physician Service Group considers many factors when offering new services or endorsing products and services for MSMS members. These include:

(1) The overall contribution to the smooth and efficient running of a physician's practice.

(2) The ability of the service or product to meet a large number of the physician's needs.

(3) The availability of the services to physicians throughout the entire state.

(4) The organization's background in the field.

(5) Its experience in dealing with physicians in the past.

(6) The PSG can provide physicians with practice building techniques (such as patient information brochures which inform new patients of location, office policy and services provided).

PSG Account Executive Caroline Rich, right, outlines the administrative services available to specialty groups for Ophelia Baker, MD, Freeland.

PSG consultants will analyze your practice, determine its strengths and recommend measures aimed at making those strengths known to patients in the area.

Information system

PSG markets the GTE Medical Information Network (MINET) to Michigan health professionals. The Medical Information Network is an electronic communication and information system which can be accessed over telephone lines from virtually any computer or termial equipped with communications capability. A user dials a local telephone number, plugs into an accoustical coupler (or connects directly via modem), signs onto the system using codes supplied by PSG and enters the world of electronic communications and information retrieval.

The GTE/MINET network features six AMA/NET data bases that are licensed and maintained by the AMA. These data bases are:

(1) Drug information, (2) Disease information, (3) Socioeconomic bibliographic information, (4) MGH - Category I CME credit offerings of the Massachusetts General Hospital, (5) EMPIRES - a biomedical bibliographic information base, and (6) CPT - medical procedure coding and nomenclature. In addition, an electronic mail system, MED/MAIL, offers instant transmission of written messages between subscribers.

For further information regarding the AMA/NET information services and GTE Telenet Medical Information Network, contact Ellen Vinocur Potash at (517) 337-1351.☐

Viola M. Heins, also an account exec with PSG, discusses newsletter production, one of several administrative services available, with Caroline Rich.

By Katharine S. Brown
Prescott, Ball and Turben, Inc.

What to do about a big profit

It seems that hardly a week goes by without at least one new takeover announcement: big news and usually a big capital gain for the shareholders. It is also increasingly common that the takeover is a cash buyout. As a result, it is a taxable transaction and, for many long term holders, a big tax liability.

As planners, we are often asked, "What can I do about the tax?" Happily, there are several alternatives to consider. These options fall into three categories: avoiding or eliminating the tax, reducing the tax and deferring the tax. However, time is very critical; if you delay tax planning, several options will be lost. Since timing and planning are so important, I will group the alternatives in sequence: before the transaction, the transaction itself and after the transaction.

Before the sale

Gifting is probably the most important pre-sale alternative. Gifting must be accomplished before the transaction in order to gain the greatest benefit. First, consider gifting shares to family members, especially when you have obligations such as children's education or parent dependency. The gift will transfer the gain to what may be a lower tax bracket, thus satisfying these obligations at reduced after-tax cost to you.

The current tax law provides for gift-tax-free transfers of up to $10,000 to any number of persons, and with your spouse, up to $20,000. Gifting also accomplishes estate planning, and therefore your unified credit can be used to expand the amount of tax-free transfer. In 1984, in addition to $10,000-20,000 to each person, you may gift up to $325,000 without tax, using your unified credit. With your spouse, that is $650,000 plus the annual exemption. Obviously, a gift of this magnitude could put the donee(s) in as high a bracket as yours, so income splitting could be lost.

Charitable gifting is another important option. Charitable gifting transfers the gain to the tax-free organization and gives you a deduction. This can be very attractive, especially when you had planned to make the donation anyway. Remember that the amount of deduction for appreciated property is limited to 30 percent of your adjusted gross income. However, excess amounts may be carried forward.

A Charitable Remainder Trust is another option involving a charitable donation. In this case the stock is transferred to a charitable trust in exchange for a life income (may include others, too). With the CRT you make a commitment to a future gift, but without the loss of current income, and you gain certain tax advantages.

First, you gain an immediate tax deduction equal to the value of the future amount that goes to the charity upon the death of the last beneficiary; second, any long-term gain is also transferred to the tax-free organization; and finally, you (and other beneficiaries) will receive a life income based on the full value of the shares contributed.

Another pre-sale alternative is the *private annuity*. This is a con-

Continued on page 664

Ms. Brown is an account executive with Prescott, Ball and Turben, investment banks and brokers, East Lansing. She is consultant to the MSMS Board of Managers on the investment of the MSMS capital and creative reserve fund assets.

Now you can have your own office at Henry Ford Hospital

Our Referring Physician Office takes care of the doctor as well as the patient.

A referral patient isn't the only one who deserves special attention. That's why we opened our new Referring Physician Office. To make the doctor's job easier. We're staffed to be of service in putting Henry Ford Hospital to work for you.

The right person to connect you with the right consulting physician.

When you call our Referring Physician Office, you get more than just a voice on the line. You get a professional: Coordinator Ardis Gregory. To her, consult problems are no problem. Which specialists do you need? She knows. How do you reach them? She'll tell you. To Ardis Gregory, there are no problems, only solutions.

Expert advice 24 hours a day.

Health problems don't follow office hours. That's why we offer Consult Line. Dial Consult Line direct (1-800-662-8242) for direct answers, any time day or night. In an emergency or to discuss a patient problem. When you need a consult, Consult Line will put you in touch with a senior physician on Henry Ford Hospital's staff. Without waiting until tomorrow.

Consult Line *1-800-662-8242*

Consult service so good, it's backed with a pledge.

- We promise to schedule an appointment within one week.
- We promise a phone call the day of the consultation or discharge.
- We promise to send a written report within five days.
- We promise to discuss any admissions with you.
- We promise that your Henry Ford Hospital consulting physician will manage your patient's care no matter how many hospital specialists are involved.
- We promise to refer your patients back to you.

We're the right vehicle to arrange transport for your patient.

Your patients can't get the care they need if they can't get here. We have access to helicopters, planes, and ambulances on constant call. Henry Ford Hospital is close to two major airports, three interstate highways, and has two helipads. To arrange a referral that involves medically-supervised transport call the Consult Line. The accepting physician will coordinate your patient's transport.

Henry Ford Hospital

Referring Physician Office

- To consult with a physician or arrange patient transport, call **24 Hour Consult Line: 1-800-662-8242**
- For general information call Ardis Gregory at **Referring Physician Office (313)876-1461**

Board of Medicine actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Licensing and Regulation.

Name: Bruce E. Fishman, MD
Action, Date Taken: License revoked effective September 30, 1984
Reason: Convicted July 14, 1983, U.S. District Ct., Eastern District of Michigan of conspiracy to distribute controlled substances.

Name: William K. Stewart, MD
Action, Date Taken: 30 day suspension effective November 1, 1984. Limited license effective December 1, prohibiting the obtaining, possession, prescribing, dispersing or administering of any substance containing amphetamines.
Reason: Branch County Circuit Court modified the board order of April 26, 1983 by reducing the period of suspension from three (3) months to thirty days.

Name: Leonard Wolin, MD
Action, Date Taken: License limited for two weeks - No operative procedures in operating room. Also reprimanded. Effective November 22, 1984.
Reason: Allowed his fourteen year old son to participate in the suturing of fascia and instructed his son to insert his hand into the patient's abdomen to feel for a catheter ball which was inserted in the bladder.

BIG PROFIT/Continued

tract under which one person (a parent, for instance) transfers to another person (a child) an asset in exchange for a life annuity (the promise to pay a certain income for life). The parent converts the stock to a fixed income for life. The amount of income is based upon the parent's age and the value of the stock. The transfer is tax-free to the parent and the child's cost is the present value. Thus, the child could sell without gain.

Note that an immediate sale may create future tax liabilities for the child. Each monthly annuity payment to the parent has three parts: (1) return of original cost (tax-free), (2) return of gain (long-term capital gain) and (3) interest on the balance (ordinary income). Thus, the gain is converted into a life income, and the tax is spread over many years.

The sale

It is important to remember that the tax on long-term capital gains is the lowest tax we pay. Sixty percent of long term capital gain income is exempt from tax (unless the alternate minimum tax applies) and therefore the maximum tax is 20 percent of the gain. For this reason, you may determine simply to pay the tax. However, a large gain can cause your tax bracket to increase to the maximum 50 percent level. In this case, you have two alternatives to hold down your tax rate.

First, you may use *income averaging* (Schedule G) to limit the increase in tax. However, even when the disparity between the current year's income and the average of the previous four years is greater, the savings will seem small.

The *installment sale* is another alternative for holding down your tax rate. For instance, if your other income puts you in a 39 percent bracket and the gain would thrust you to the 50 percent rate, you can reduce the tax rate by spreading the gain over more than one year. With an installment sale, you are taxed on the gain only as you receive the proceeds. You may establish such a transaction with any person or organization.

You should be aware that new regulations make certain intra-family installment sales less attractive.

After the sale

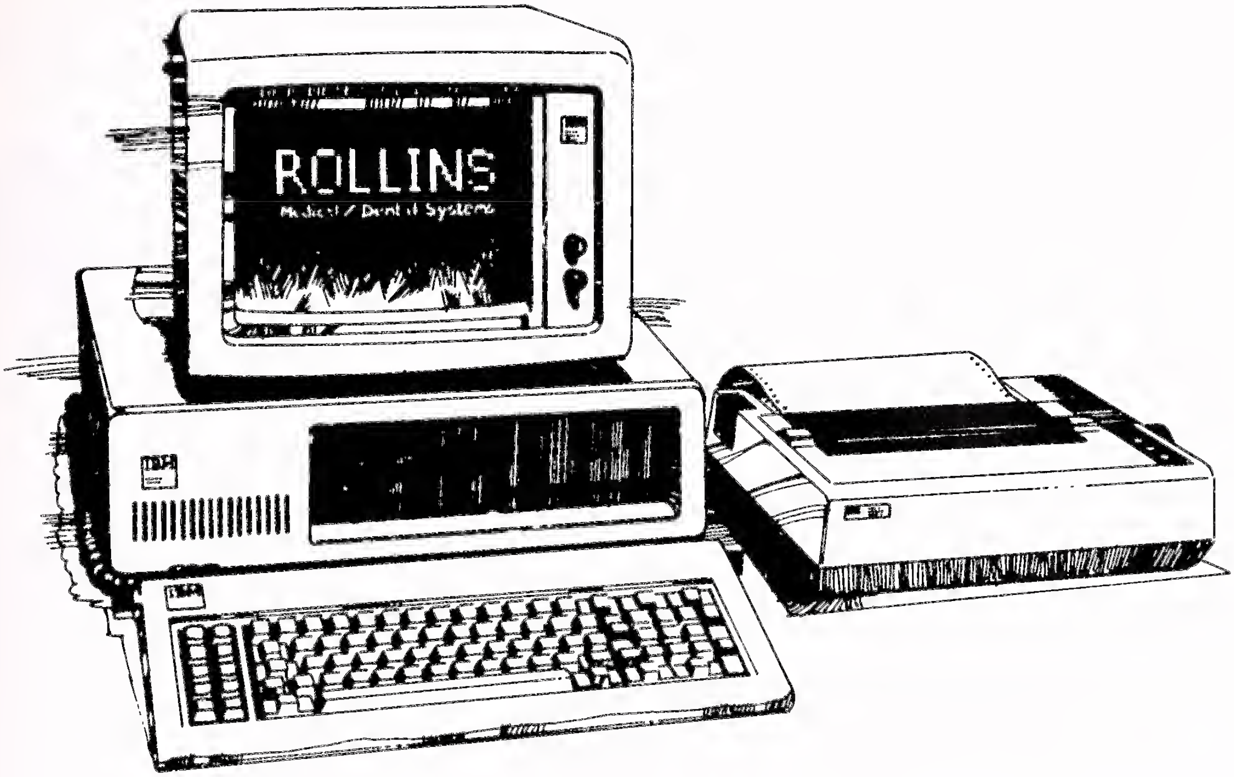
Unfortunately, most people come to me after the sale when the alternatives remaining are limited. Though pre-sale gifting is best, post-sale charitable gifting may still be attractive when the gain has increased your tax bracket and you plan to make the donation anyway. Consider bunching two or three years' giving in the year of the gain.

Review your other investments and consider tax loss sales. Losses will offset gains dollar-for-dollar. But remember that excess losses also offset other income up to $3,000 per year. Therefore, it may be more advantageous to take long-term capital gains in one year and the losses in another.

Finally, taxes may be deferred and/or converted to a lower rate by the use of *artificial accounting losses*. Such deductions are created by various tax-shelter investments. Since the gain is a singular event, the tax-shelter technique used should provide a large deduction relative to the dollars invested. For this reason, oil and gas drilling partnerships are among the most effective. Here, of course, you trade a known tax liability for an unknown future benefit. A sound venture with good economic results can convert a good investment to a better one through tax deferral.

Pitfalls

Whenever the long-term capital gain is extremely large in relation to your other taxable income, you may find that the alternative minimum tax (AMT) applies. This tax is computed including the excluded 60 percent portion of the gain. Though the minimum AMT rate is only 20 percent, it will apply whenever it produces a larger tax than the regular schedule. In this event, both charitable gifting and tax shelters become less attractive. For this reason, we urge you to consult a tax advisor when planning strategies involving a large long-term capital gain. ☐



This is the best investment you can make in your practice.

An investment in time

The Rollins Medical Office System drastically reduces the time required to process paperwork. It prints claim forms in seconds and prints month-end statements automatically, unattended. It increases staff productivity and efficiency. At the end of the working day, all the day's paperwork is done. No backlog means faster payment.

An investment in quality

The Rollins Medical Office System offers the best software and hardware combination available. The software is very sophisticated, state of the art, yet is very simple to use. The IBM equipment gives you a range of models and options, so your system is tailored specifically to your needs. And of course, IBM has the best service record in the industry.

An investment in accuracy

The Rollins Medical Office System gives you accurate information about who owes you how much and for how long. It also keeps track of balances automatically, so it minimizes figuring and transposing errors. It records codes and fees automatically on claim forms, so it cuts down on the number of rejected claim forms. Also, the itemized patient month-end statements eliminate patient confusion and telephone calls at month-end.

Ask us about the other investment advantages, including investment tax credits and depreciation. These even further reduce your cost while making your practice more profitable. Call us now. We'll be happy to show you how the Rollins Medical System can work for you.

ROLLINS
Medical / Dental Systems
360 Clausen Building
23100 Providence Drive
Southfield, Michigan 48075-3677
Phone (313) 423-7200

An IBM value-added remarketer

YES I'd like to know more about the Rollins System

Name ____________________
Practice Name ____________________
Address ____________________
City ____________ State ____________
Zip ____________ Phone ____________

Mail to: ROLLINS Medical/Dental Systems
360 Clausen Bldg., 23100 Providence Dr.
Southfield, MI 48075-3677

Professional
INSTALLMENT LOANS

$15,000
TO
$90,000

Decision In
24 to 48 Hours!

Same-Day Answer to Applications Received By Express Mail

- Deal Directly With Lender
- Deferred Payment Plans
- No Prepayment Penalty
- No Restriction on Use of Funds For:
  Investments
  Payment of Taxes
  Debt Consolidation
  Tax Shelters
  Pension Plan Contributions

Ask for Tom Todd

CALL TOLL FREE:
800-423-5025

Serving The Medical Profession Since 1966

WOODSIDE CAPITAL CORP.
National Headquarters
Woodside Capital Building
21424 Ventura Boulevard
Woodland Hills, California 91364

Component societies have close ties to Board and staff

Every component medical society is represented on the MSMS Board of Directors by one or more elected physicians, depending on the size of that group's membership. In addition, an MSMS staff member is assigned as liaison and resource person to each component society. These contact persons are indicated below.

ALLEGAN COUNTY
Director: Thomas R. Berglund, MD
Staff: Kirk McMurray

ALPENA-ALCONA-PRESQUE ISLE COUNTIES
Director: Charles L. Oppy, MD
Staff: Jerome Trahan

BARRY COUNTY
Directors: Harvey M. Andre, MD
Kornelius VanGoor, MD
Staff: Katie Brewbaker

BAY-ARENAC-IOSCO COUNTIES
Director: Charles L. Oppy, MD
Staff: Vada L. Davis

BERRIEN COUNTY
Director: Thomas R. Berglund, MD
Staff: Katie Brewbaker

BRANCH COUNTY
Director: William D. Walters, MD
Staff: Kirk McMurray

CALHOUN COUNTY
Director: William D. Walters, MD
Staff: Judith E. Marr

CASS COUNTY
Director: Thomas R. Berglund, MD
Staff: Vada L. Davis

CHIPPEWA-MACKINAC COUNTIES
Director: Carl F. Hammerstrom, MD
Staff: Sherry N. Wellman
Jerome Trahan

CLINTON COUNTY
Director: Justin L. Sleight, MD
Staff: Katie Brewbaker

DELTA COUNTY
Director: Carl F. Hammerstrom, MD
Staff: Deborah Zannoth

DICKINSON-IRON COUNTIES
Director: Kenneth E. Rowe, MD
Staff: Sherry N. Wellman
Jerome Trahan

EATON COUNTY
Director: Justin L. Sleight, MD
Staff: Judith E. Marr

GENESEE COUNTY
Director: Richard L. Rapport, MD
Staff: Richard M. Campau

GOGEBIC COUNTY
Director: Kenneth E. Rowe, MD
Staff: Sherry N. Wellman
Jerome Trahan

GR. TRAVERSE-LEELANAU-BENZIE COUNTIES
Director: Kenneth E. Rowe, MD
Staff: Sherry L. Fent

GRATIOT COUNTY
Director: Jack L. Barry, MD
Staff: John A. Richards

HILLSDALE COUNTY
Director: Justin L. Sleight, MD
Staff: Kirk McMurray

HOUGHTON-BARAGA-KEWEENAW COUNTIES
Director: Kenneth E. Rowe, MD
Staff: Sherry N. Wellman
Jerome Trahan

HURON COUNTY
Director: Kenneth B. Herrington, MD
Staff: Sherry L. Fent

INGHAM COUNTY
Director: Justin L. Sleight, MD
Staff: Judith E. Marr

IONIA-MONTCALM COUNTIES
Directors: Harvey M. Andre, MD
Kornelius Van Goor, MD
Staff: Linda Munson

ISABELLA-CLARE COUNTIES
Director: Jack L. Barry, MD
Staff: Vada L. Davis

JACKSON COUNTY
Director: Justin L. Sleight, MD
Staff: Ellen Vinocur Potash

KALAMAZOO COUNTY
Director: Thomas R. Berglund, MD
Staff: Linda Munson

KENT COUNTY
Directors: Harvey M. Andre, MD
Kornelius Van Goor, MD
Staff: Linda Munson

LAPEER COUNTY
Director: Kenneth B. Herrington, MD
Staff: Sherry L. Fent

LENAWEE COUNTY
Director: Marguerite Shearer, MD
Staff: Daniel Farhat

LIVINGSTON COUNTY
Director: Marguerite Shearer, MD
Staff: Daniel Farhat

Continued on page 668

OBESITY.

THE CONSEQUENCES CAN BE LIFE-SHORTENING.

As physicians, every one of us knows the consequences of obesity: cardiovascular disease. . . diabetes. . . hypertension. . . congestive heart failure. . . an increased risk of sudden death.

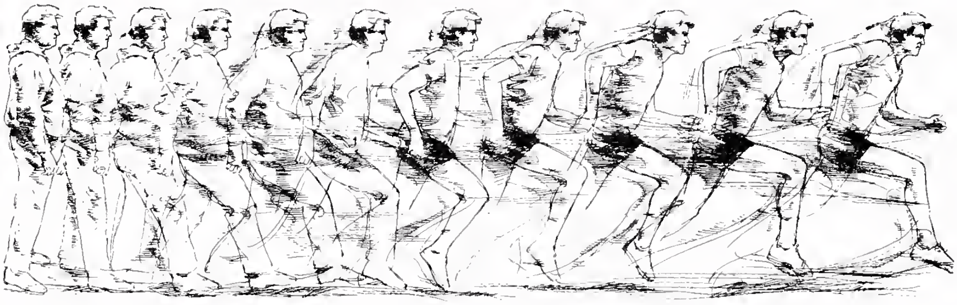
Most of us also recognize how difficult it is for the obese patient to lose weight, not to mention the frustrations and failures that attend long-term maintenance of normal weight.

The Institute for Health Maintenance (IHM) can help.

Working in conjunction with a patient's primary care physician, IHM offers a medically sound regimen for therapeutic weight loss: THE RISK FACTOR OBESITY PROGRAM (RFO).

Developed under clinical conditions at major medical teaching institutions, the RFO Program combines a medically supervised supplemented fast with long-term behavioral and nutritional training.

Under the supervision of physicians and their staff, patients lose weight safely and consistently over a period of weeks and months, receiving their total daily nutritional requirements from a low-calorie egg albumen formulation supplemented with potassium and vitamins.



The success of the RFO Program has been significant.

Over the past five years, more than ten thousand patients have lost from 25 to over 400 pounds, with an average weight loss of 63 pounds. More important, 50% of patients admitted to our program have been able to sustain their new low weight levels for one year with the help of long-term maintenance.

Some patients have called the RFO Program "life-saving." As physicians, we know the relationship between certain risk factors and longevity. Obesity is one of those factors—one we can help reduce.

To learn more about us and how this program can safely benefit some of your patients, please contact University Health Center, 4201 St. Antoine, Detroit, Michigan 48201. (313) 832-2460.

The Risk Factor Obesity Program

Medically designed. Medically supervised. Medically sound.

LUCE COUNTY
Director: Carl F. Hammerstrom, MD
Staff: Sherry N. Wellman
Jerome Trahan

MACOMB COUNTY
Directors: Frederick W. Bryant, MD
Billy Ben Baumann, MD
Joel W. Clay, MD
Staff: Richard M. Campau

MANISTEE COUNTY
Director: Vickers C. Hansen, MD
Staff: John A. Richards

MARQUETTE-ALGER COUNTIES
Director: Carl F. Hammerstrom, MD
Staff: Sherry N. Wellman
Jerome Trahan

MASON COUNTY
Director: Robert E. Paxton, MD
Staff: Wayne E. Burmeister

MECOSTA-OSCEOLA-LAKE COUNTIES
Director: Robert E. Paxton, MD
Staff: Wayne E. Burmeister

MENOMINEE COUNTY
Director: Kenneth E. Rowe, MD
Staff: Sherry N. Wellman
Jerome Trahan

MIDLAND COUNTY
Director: Jack L. Barry, MD
Staff: Deborah Zannoth

MONROE COUNTY
Director: Marguerite Shearer, MD
Staff: Kevin Kelly

MUSKEGON COUNTY
Director: Robert E. Paxton, MD
Staff: Dan Farhat

NEWAYGO COUNTY
Director: Robert E. Paxton, MD
Staff: Wayne Burmeister

NORTH CENTRAL
Director: Charles L. Oppy, MD
Staff: Richard Campau

NORTHERN MICHIGAN
Director: Vickers C. Hansen, MD
Staff: Deborah Zannoth

OAKLAND COUNTY
Directors: Frederick W. Bryant, MD
Billy Ben Baumann, MD
Joel W. Clay, MD
Staff: Kevin Kelly

OCEANA COUNTY
Director: Robert E. Paxton, MD
Staff: Wayne Burmeister

ONTONAGON COUNTY
Director: Kenneth E. Rowe, MD
Staff: Sherry N. Wellman
Jerome Trahan

OTTAWA COUNTY
Directors: Harvey M. Andre, MD
Kornelius Van Goor, MD
Staff: Kirk McMurray

SAGINAW COUNTY
Director: Jack L.Barry, MD
Staff: Kevin Kelly

ST. CLAIR COUNTY
Director: Kenneth B. Herrington, MD
Staff: Ellen Vinocur Potash

ST. JOSEPH COUNTY
Director: William D. Walters, MD
Staff: John A. Richards

SANILAC COUNTY
Director: Kenneth B. Herrington, MD
Staff: Sherry L. Fent

SCHOOLCRAFT COUNTY
Director: Carl F. Hammerstrom, MD
Staff: Sherry N. Wellman
Jerome Trahan

SHIAWASSEE COUNTY
Director: Richard L. Rapport, MD
Staff: Deborah Zannoth

TUSCOLA COUNTY
Director: Jack L. Barry, MD
Staff: Ellen Vinocur Potash

VAN BUREN COUNTY
Director: Thomas R. Berglund, MD
Staff: Kevin Kelly

WASHTENAW COUNTY
Director: Marguerite Shearer, MD
Staff: John A. Richards

WAYNE COUNTY
Directors: Henry M. Domzalski, MD
Carl A. Gagliardi, MD
James J. Humes, MD
Kenneth J. Ray, MD
Arthur A. Ulmer, MD
Frank B. Walker, MD
Staff: Ellen Vinocur Potash

WEXFORD-MISSAUKEE COUNTIES
Director: Vickers C. Hansen, MD
Staff: Richard Campau

A WORD TO THE WHYS

WHY AMA? The AMA provides a democratic forum where you, along with your colleagues across the country, can raise and argue issues, reach a consensus and formulate policy. AMA policy is then translated into practical actions on issues that affect you and your practice. Making sure medicine stays active, strong and united: it's one more good reason why you should be a part of the AMA.

WHY AMA? The AMA helps maintain high standards in Continuing Medical Education through its participation in the Accreditation Council for Continuing Medical Education (ACCME). The AMA also helps reduce the high cost of CME by offering 28 Video Clinic study courses for CME credit. Upholding CME standards and providing cost-effective CME alternatives: it's one more good reason why you should be a part of the AMA.

To Join, Contact your county or state medical society or write: Division of Membership, AMA, 535 North Dearborn Street, Chicago, Illinois 60610 or call collect, (312) 751-6196.

SOURCE SYSTEMS INC.

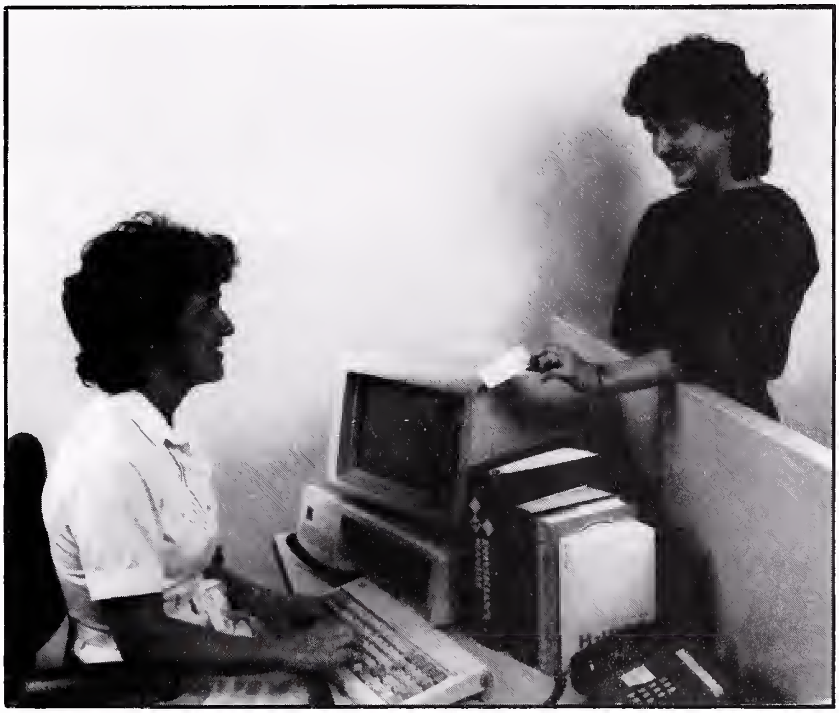
The Specialist

Your Total Medical Office
Management Resource

The system that handles ***All*** of your administrative needs.

*When your practice requires your undivided medical attention, it's nice having a **Specialist** handling your non-medical worries.*

The ***Specialist*** - designed to ease the patient billing and claims processing tasks.
The ***Specialist*** keeps accurate patient records on billings, schedules appointments, prints recall labels, chart-pull lists and charge slips.
The ***Specialist*** offers hardware, software, installation management, user training, on-going support, service and consulting.



The ***Specialist.***

Medical Billing, Practice Productivity Analysis, Appointment Scheduling and much more.

Key System Features

- *Multi-user/Multi-work station*
- *IBM reliability*
- *Expandable, as your practice grows*
- *60 day full refund policy*
- *Automatic input into the Blue Shield system*
- *Custom insurance form generation*
- *Family and individual account detail*
- *Password protected information*

Make the Specialist your total office management resource.

I am interested in more information on the ***Specialist.***
Please provide additional details.
Name ______________________________
Address ______________________________
City ______________ State __________ Zip __________
No. of Physicians in practice ______________
Physician speciality ______________________

SOURCE SYSTEMS INC.

1383 Woodward Avenue, Suite 204
Bloomfield, Mi 48013
(313) 335-1400

Sometimes you just can't operate alone.

When it comes to saving lives, teamwork becomes not only desirable; it becomes necessary.

In an operating room, in an emergency room, in consultation with other physicians, teamwork helps you do your job to the best of your ability.

The American Medical Association and your state and county medical societies believe in the value of teamwork — and the necessity of it, in the face of an increasingly complex professional environment.

We also believe that medical societies have certain tasks that the individual physician couldn't possibly assume — and shouldn't have to.

For example, to keep government regulations from interfering with your practice, we effectively represent your interests at local and national levels.

To influence policies of organized medicine with which you disagree, we provide the means to have your views heard and respected.

And to keep you up to date on the latest medical advances, we publish JAMA, AM News, specialty, state, and county journals.

In fact, for all the times you can't operate alone, your medical societies will be there. Working with you to defend your rights and protect your freedoms.

Join Your Medical Societies Today.

For more information, contact your county or state medical societies, or call the AMA collect at 312/751-6196. Or return the coupon below to your state or county medical society.

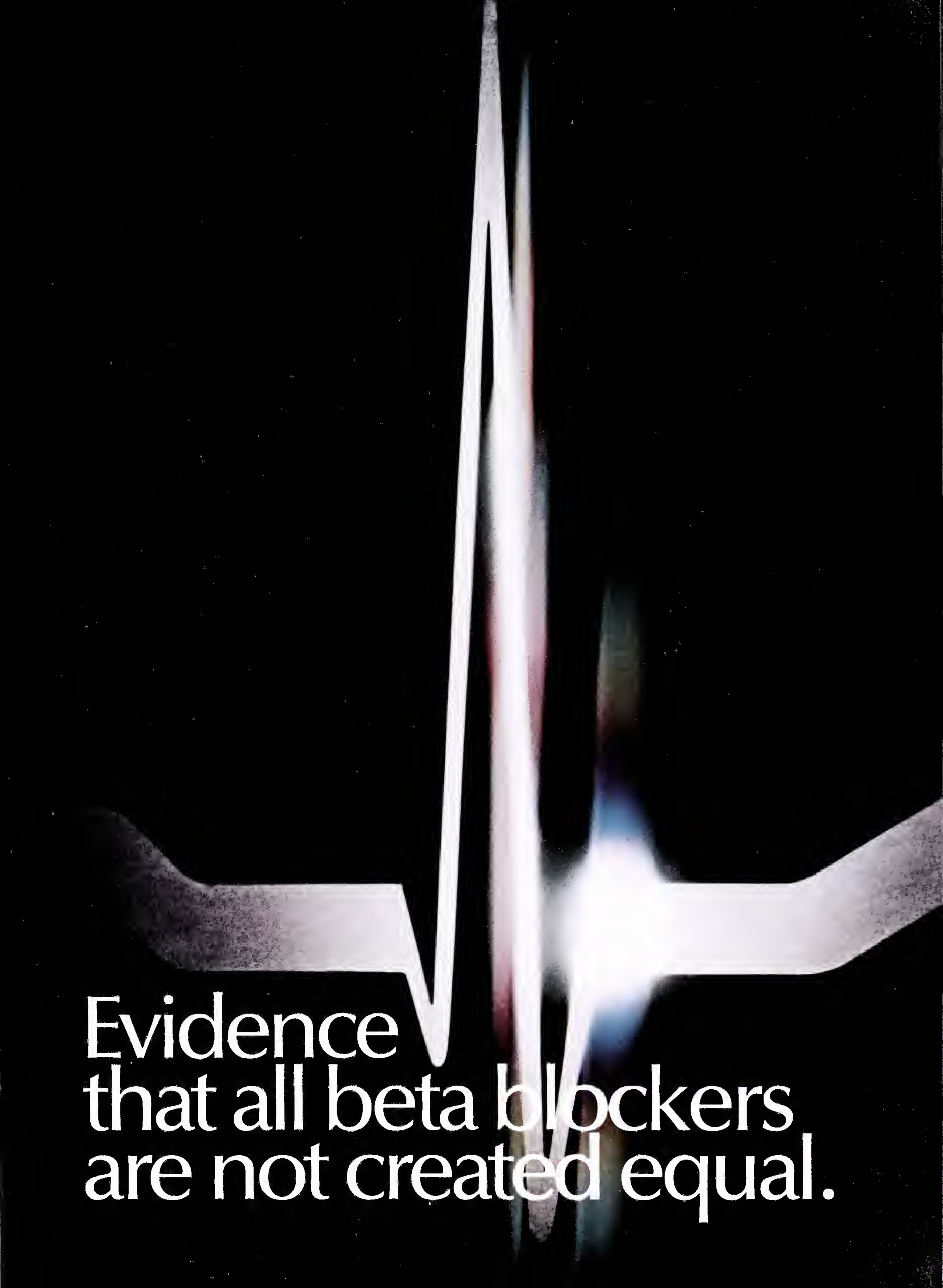
☐ Please send me information on AMA, county, and state society membership.
☐ I am a member of my county and state societies; please send me information on joining the AMA.

Name ______________________________

Street ______________________________

City ______________ State ______________ Zip __________

County ______________________________


Evidence
that all beta blockers
are not created equal.

New studies uncover the potassium effects of beta-2 blockade

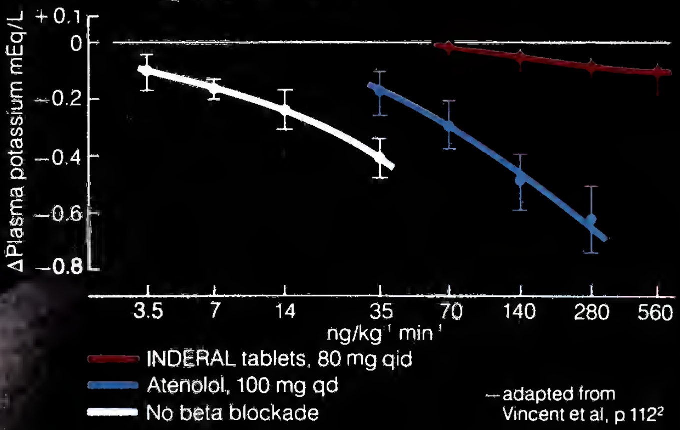
Clinical pharmacology data from the *New England Journal of Medicine:*

"...when normal young men are given infusions of epinephrine at levels such as those that circulate in patients with myocardial infarction, their serum potassium concentrations fall by about 0.8 mmol per liter. Hypokalemia is prevented by...beta-2 blockade."[1]

INDERAL (propranolol HCl) prevented beta-2 mediated hypokalemia

In a pharmacological study comparing INDERAL with atenolol, 10 hypertensive patients were infused with the nonselective beta agonist, isoproterenol, which also stimulates beta-2 mediated hypokalemia. At doses high enough to overcome beta-1 mediated heart rate reductions, the hypokalemia caused by isoproterenol was blunted by INDERAL, but not by atenolol.[2]

INDERAL compared with atenolol: change in plasma potassium after beta-agonist infusion[2]



—adapted from Vincent et al, p 112[2]

For beta-1/beta-2 blockade

INDERAL

(PROPRANOLOL HCl)

Please see last page for brief summary of prescribing information.

Epinephrine-induced hypokalemia can intensify diuretic-induced hypokalemia

From the *Lancet:*

"Although both diuretics and adrenaline are known to cause hypokalaemia, we believe that this is the first demonstration that these two factors can act in an additive manner. Routine monitoring of serum potassium in patients on thiazide diuretics may underestimate the risks of hypokalaemia."[3]

Epinephrine drives potassium into cells—an effect that has been shown to be under beta-2 receptor control[4]; thiazides promote excretion of potassium. When these actions occur together, hypokalemia can intensify significantly.[3]

Epinephrine-induced hypokalemia can cause ECG abnormalities typical of other forms of hypokalemia

In a study of the effects of epinephrine-induced hypokalemia on the electrocardiogram, it was shown that levels of plasma epinephrine similar to those observed during myocardial infarction can produce changes in ventricular repolarization, which are reflected in T-wave flattening and QT prolongation in normal subjects.[5]

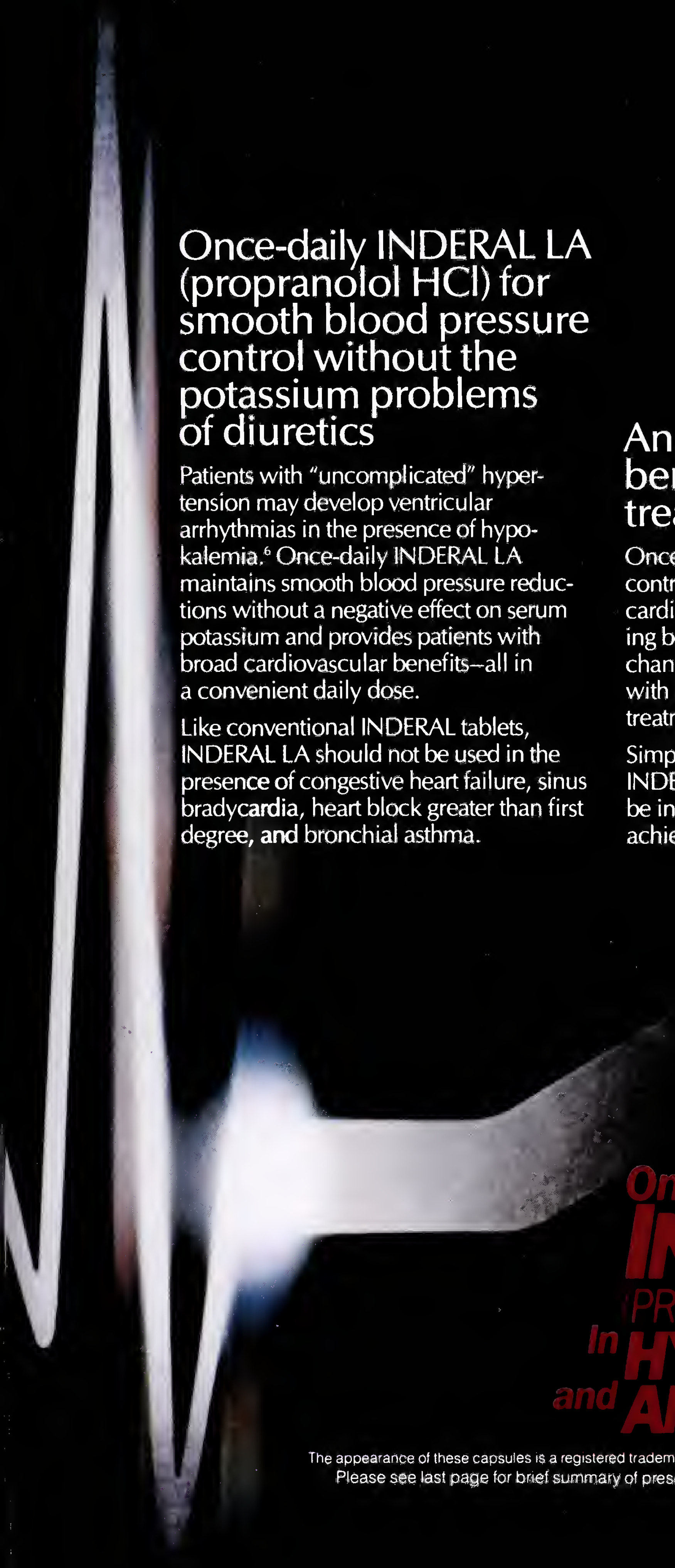
In clinical pharmacology studies of hypertensive and normal patients, epinephrine-induced hypokalemia was prevented by beta-2 blockade.[2,4]

For beta-1/beta-2 blockade INDERAL®
(PROPRANOLOL HCl) TABLETS

Please see last page for brief summary of prescribing information.

Right from the start
in hypertension...

SPHYGMOMANOMETER
20
40
60
80
100
120
140
160
180
200
220
240
260
280
300



Once-daily INDERAL LA (propranolol HCl) for smooth blood pressure control without the potassium problems of diuretics

Patients with "uncomplicated" hypertension may develop ventricular arrhythmias in the presence of hypokalemia.[6] Once-daily INDERAL LA maintains smooth blood pressure reductions without a negative effect on serum potassium and provides patients with broad cardiovascular benefits—all in a convenient daily dose.

Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

And for lifetime benefits in foundation treatment of angina

Once-daily INDERAL LA provides 24-hour control of angina symptoms—plus the cardiovascular benefits of the world's leading beta blocker. And unlike calcium channel blockers, INDERAL LA, alone or with a nitrate, is recommended for first-line treatment of stable angina.

Simply start new patients on 80 mg INDERAL LA once daily. Dosage may be increased to 160 mg once daily to achieve maximal control.

Once-daily
INDERAL LA
PROPRANOLOL HCl
In HYPERTENSION
and ANGINA

AL LA
AL LA
AL LA
80 mg
120 mg
160 mg

The appearance of these capsules is a registered trademark of Ayerst Laboratories.
Please see last page for brief summary of prescribing information.

INDERAL®
(PROPRANOLOL HCl) TABLETS

10 mg 20 mg 40 mg 60 mg 80 mg 90 mg

The appearance of these tablets is a registered trademark of Ayerst Laboratories.

Once-daily
INDERAL® LA
(PROPRANOLOL HCl) LONG ACTING CAPSULES

80 mg
120 mg
160 mg
RAL LA
RAL LA
RAL LA

The appearance of these capsules is a registered trademark of Ayerst Laboratories.

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULARS.)*
INDERAL® (propranolol hydrochloride) **Tablets and Injectable**
INDERAL® LA (propranolol hydrochloride) **Long Acting Capsules**

INDICATIONS AND USAGE—INDERAL Tablets

Hypertension: INDERAL (propranolol hydrochloride) is indicated in the management of hypertension. It may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL is not indicated in the management of hypertensive emergencies

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL is indicated for the long-term management of patients with angina pectoris

Cardiac Arrhythmias:

1.) Supraventricular arrhythmias

a) Paroxysmal atrial tachycardias, particularly those arrhythmias induced by catecholamines or digitalis or associated with the Wolff-Parkinson-White syndrome. (See W-P-W under WARNINGS.) b) Persistent sinus tachycardia which is noncompensatory and impairs the well-being of the patient. c) Tachycardias and arrhythmias due to thyrotoxicosis when causing distress or increased hazard and when immediate effect is necessary as adjunctive, short term (2-4 weeks) therapy. May be used with, but not in place of, specific therapy. (See Thyrotoxicosis under WARNINGS.) d) Persistent atrial extrasystoles which impair the well-being of the patient and do not respond to conventional measures. e) Atrial flutter and fibrillation when ventricular rate cannot be controlled by digitalis alone, or when digitalis is contraindicated

2.) Ventricular tachycardias

Ventricular arrhythmias do not respond to propranolol as predictably as do the supraventricular arrhythmias. a)Ventricular tachycardias. With the exception of those induced by catecholamines or digitalis, INDERAL is not the drug of first choice. In critical situations when cardioversion technics or other drugs are not indicated or are not effective, INDERAL may be considered. If, after consideration of the risks involved, INDERAL is used, it should be given intravenously in low dosage and very slowly. (See DOSAGE AND ADMINISTRATION.) *Care in the administration of* INDERAL *with constant electrocardiographic monitoring is essential as the failing heart requires some sympathetic drive for maintenance of myocardial tone.* b) Persistent premature ventricular extrasystoles which do not respond to conventional measures and impair the well-being of the patient

3.) Tachyarrhythmias of digitalis intoxication

If digitalis-induced tachyarrhythmias persist following discontinuance of digitalis and correction of electrolyte abnormalities, they are usually reversible with *oral* INDERAL. Severe bradycardia may occur. (See OVERDOSAGE.) Intravenous propranolol hydrochloride is reserved for life-threatening arrhythmias. Temporary maintenance with oral therapy may be indicated. (See DOSAGE AND ADMINISTRATION in the package circulars.)

4.) Resistant tachyarrhythmias due to excessive catecholamine action during anesthesia

Tachyarrhythmias due to excessive catecholamine action during anesthesia may sometimes arise because of release of endogenous catecholamines or administration of catecholamines. When usual measures fail in such arrhythmias, INDERAL may be given intravenously to abolish them. All general inhalation anesthetics produce some degree of myocardial depression. Therefore, when INDERAL (propranolol hydrochloride) is used to treat arrhythmias during anesthesia, it should be used with extreme caution and constant ECG and central venous pressure monitoring. (See WARNINGS.)

Myocardial Infarction: INDERAL is indicated to reduce cardiovascular mortality in patients who have survived the acute phase of myocardial infarction and are clinically stable

Migraine: INDERAL is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta receptor stimulation. Clinical improvement may be temporary

Pheochromocytoma: After primary treatment with an alpha-adrenergic blocking agent has been instituted, INDERAL may be useful as *adjunctive* therapy if the control of tachycardia becomes necessary before or during surgery

It is hazardous to use INDERAL unless alpha-adrenergic blocking drugs are already in use, since this would predispose to serious blood pressure elevation. Blocking only the peripheral dilator (beta) action of epinephrine leaves its constrictor (alpha) action unopposed.

In the event of hemorrhage or shock, there is a disadvantage in having both beta and alpha blockade since the combination prevents the increase in heart rate and peripheral vasoconstriction needed to maintain blood pressure.

With inoperable or metastatic pheochromocytoma, INDERAL may be useful as an adjunct to the management of symptoms due to excessive beta receptor stimulation.

INDICATIONS AND USAGE—INDERAL LA Long Acting Capsules

Hypertension: INDERAL LA (propranolol hydrochloride) is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL and INDERAL LA are contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL (propranolol hydrochloride) therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY. The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures

INDERAL, like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia, visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

REFERENCES.

1. Epstein FH, Rosa RM: Adrenergic control of serum potassium. *N Engl J Med* 1983;309 1450-1451. **2.** Vincent HH, Boomsma F, Man in't Veld AJ, et al: Effects of selective and nonselective β-agonists on plasma potassium and norepinephrine. *J Cardiovasc Pharmacol* 1984;6:107-114. **3.** Struthers AD, Whitesmith R, Reid JL: Prior thiazide diuretic treatment increases adrenaline-induced hypokalaemia. *Lancet* 1983;1:1358-1361. **4.** Brown MJ, Brown DC, Murphy MB: Hypokalemia from beta$_2$-receptor stimulation by circulating epinephrine. *N Engl J Med* 1983;309:1414-1419. **5.** Struthers AD, Reid JL, Whitesmith R, et al: Effect of intravenous adrenaline on electrocardiogram, blood pressure, and serum potassium. *Br Heart J* 1983;49:90-93. **6.** Holland OB, Nixon JV, Kuhnert L: Diuretic-induced ventricular ectopic activity. *Am J Med* 1981;70:762-768.

9410/1184

Ayerst®
AYERST LABORATORIES
New York, N.Y. 10017

Copyright © 1984 AYERST LABORATORIES
Division of AMERICAN HOME PRODUCTS CORPORATION

Amicus Curiae brief

By Kerr, Russell and Weber

Can confidential records be subpoenaed?

MSMS, at its July 28, 1984 Board meeting unanimously voted to join in an Amicus Curiae brief regarding two statewide cases. One case, "Attorney General v Sandra G. Bruce and Berrien General Hospital," is published here in its entirety.

The MSMS Board unanimously approved this legal action in order to maintain the privileged and confidential nature of physician peer review activities statewide. MSMS believes its members would be interested in the following brief submitted to the State of Michigan Supreme Court. The second Amicus Curiae brief will be published in a future issue of *Michigan Medicine*. For further details contact William E. Madigan, managing director, MSMS.

V. **STATEMENT OF THE ISSUE PRESENTED**

I. CAN THE ATTORNEY GENERAL, DURING AN INVESTIGATION CONDUCTED BY THE DEPARTMENT OF LICENSING AND REGULATION, SUBPOENA THE RECORDS, DATA AND KNOWLEDGE OF A HOSPITAL PEER REVIEW COMMITTEE WHERE THE INFORMATION GATHERED BY THE COMMITTEE IS DEEMED BY THE LEGISLATURE TO BE PRIVILEGED AND CONFIDENTIAL?

The trial court answered "Yes".
The Court of Appeals answered "No".
Amicus Curiae contends the response should be "No".

vi

INTEREST OF MICHIGAN STATE MEDICAL SOCIETY

Michigan State Medical Society (hereinafter "MSMS") has a significant interest in the outcome of the issues presented to this Court in this action. MSMS represents the professional interests of over 10,000 licensed physicians in the State of Michigan. The vast majority of these members are staff members at licensed hospitals located throughout the state. Consequently, many MSMS members actively participate in various peer review programs functioning within our state's hospitals.

MSMS is concerned with maintaining the privileged and confidential nature of the physician peer review activities conducted statewide. Confidentiality of peer review investigations is essential to the candor necessary for an effective reviewing process. Without the assurance of confidentiality in these proceedings, health care professionals would not be as willing, if at all, to critically and objectively evaluate a colleague's professional conduct.

Amicus curiae believes that the Michigan Legislature, through the enactment of Part 215 of Article 17 of the Public Health Code, MCLA 333.21501, *et seq*, has determined that there is an overwhelming public interest in keeping hospital peer review investigations privileged and confidential so that the flow of ideas and advice will continue uninhibited. To subject the investigative data and records of a peer review committee to discovery by the Attorney General would only hinder the goal of effective and continuing improvement in the care and treatment of hospital patients.

Supreme Court No. 71645

ATTORNEY GENERAL, Plaintiff-Appellant, v. SANDRA G. BRUCE and BERRIEN GENERAL HOSPITAL, Defendants-Appellees. COA No., 63437, Ingham CCC No. 82-28994-CZ.AMICUS CURIAE BRIEF OF MICHIGAN STATE MEDICAL SOCIETY - STATEMENT OF FACTS: *Amicus Curiae* incorporates the Statement of Facts set forth in the Brief of Appellees, SANDRA G. BRUCE and BERRIEN GENERAL HOSPITAL.

ARGUMENT

I. INFORMATION GATHERED BY A HOSPITAL PEER REVIEW COMMITTEE CONCERNING THE QUALITY OF CARE AND TREATMENT PROVIDED BY STAFF MEMBERS IS CONFIDENTIAL AND NOT SUBJECT TO SUBPOENA BY THE ATTORNEY GENERAL DURING AN INVESTIGATION CON-

Continued on page 680

The Detroit-based law firm of Kerr, Russell and Weber, celebrating its 110th anniversary of practice, is MSMS legal counsel.

DUCTED BY THE DEPARTMENT OF LICENSING AND REGULATION.

The Attorney General, through an investigative subpoena issued by the trial court, seeks to compel discovery of information gathered by the internal peer review committee of Berrien General Hospital in the course of the committee's investigation into the care and treatment provided by one of its staff members. The Michigan Public Health Code ("Code"), which requires licensed hospitals in the state to conduct continuing internal peer reviews of its professional staff, provides that information collected by a peer review committee is confidential and, therefore, not subject to disclosure through the judicial discovery process. MCLA 333.-20175(5); MCLA 333.21515. The Court of Appeals correctly held that the language of the Code addressing the confidential nature of a hospital's peer review investigation is unequivocal and unambiguous. *Attorney General v Bruce,* 15 Mich App 796 (1983), *lv granted,* 418 Mich 954 (1984). The Attorney General's investigative subpoena in this action, therefore, should be quashed.

A. **The Michigan Legislature, Through The Public Health Code, Absolutely And Unequivocally Protects, As Privileged And Confidential, The Records, Data And Knowledge Collected By A Hospital Peer Review Committee.**

Part 215 of Article 17 of the Public Health Code, MCLA 333.21501, *et seq,* enunciates certain duties and responsibilities that a licensed hospital must fulfill. Specifically, (SS) 21513(d) requires the hospital to conduct continuing peer review investigations to insure high quality patient care.

> "The owner, operator and governing body of a hospital licensed under this article . . . [s]hall insure that physicians admitted to practice in the hospital are organized into a medical staff to enable an effective review of the professional practices in the hospital for the purpose of reducing morbidity and mortality and improving the care provided in the hospital for patients. This review shall include the quality and necessity of the care provided and the preventability of complications and deaths occurring in the hospital." MCLA 333.21513(d).

While the governing board of each hospital bears the ultimate responsibility of maintaining an internal peer review system, this responsibility is generally delegated to the hospital's medical staff which, in turn, formulates peer review committees comprised of medical staff members. *See* Anno: *Discovery of Hospital's Internal Records Or Communications As To Qualifications Or Evaluations of Individual Physicians,* 81 ALR3d 944, 946. *See also* the *Accreditation Manual For Hospitals* published by the Joint Commission On Accreditation of Hospitals ("JCAH"), 1980 ed, Medical Staff, p 93.

Whenever a hospital review committee's investigation of a medical staff member results in disciplinary action taken by the hospital, the hospital must notify the appropriate licensing board and the Department of Licensing and Regulation (hereinafter "Department") of the basis of its disciplinary action. MCLA 333.20175(4). The hospital, however, is not required, and cannot be compelled, to disclose the information gathered by the peer review committee which resulted in the recommendation for disciplinary action. MCLA 333.20175(5).

> "(4) A health facility or agency with a medical staff shall report to the appropriate licensing board and to the department not more than 30 days after any disciplinary action has been taken against a member of the medical staff, and the relevant circumstances, for any of the grounds set forth in Section 16221 [MCLA 333.16221].
>
> "(5) The records, data and knowledge collected for or by individuals or committees assigned a professional review function in a health facility or agency are confidential, shall be used only for the purposes provided in this article, are not public records, and are not subject to court subpoena." MCLA 333.20175(4) and (5).

The privileged and confidential nature of peer review committee communications is reiterated by the Legislature in the provision which directly follows the Code's requirement that a hospital establish a continuing internal peer review system. MCLA 333.21513.

> "The records, data and knowledge collected for or by individuals or committees assigned a review function described in this article are confidential and shall be used only for the purposes provided in this article, shall not be public records, and shall not be available for court subpoena." MCLA 333.21515.

The Michigan courts have consistently held that when a statute has a plain and unambiguous meaning, the statute

Continued on page 682

Billing Department:
Advance Medical & Research Center, Inc. has developed one of the most comprehensive and efficient billing systems in the laboratory industry. Highly sophisticated data processing hardware and software systems make it possible for AMRC to provide the various billing options required by our physician clients and their patients.

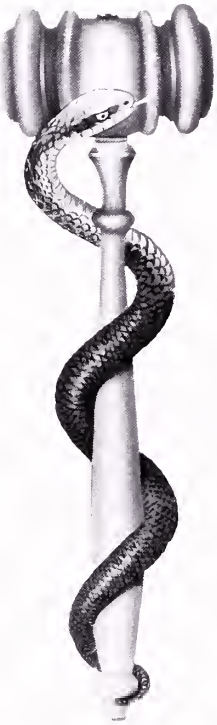
Advance Medical & Research Center, Inc.
1270 Doris Rd. • Pontiac, Michigan 48057 • (313) 373-9120
Branches: Allen Park, Alpena, East Jordan, Flint,
Grand Rapids, Kalamazoo, Lansing, Monroe, Traverse City

Serving the medical profession since 1963

must be applied as promulgated and cannot be subject to judicial construction, interpretation or debate. *Citizens For Justice v Goldfarb,* 415 Mich 255, 275 (1982); *City of Lansing v Twp of Lansing,* 356 Mich 641 (1959); *Lawrence v Department of Corrections,* 88 Mich App 167 (1979). In two separate provisions of Article 17 of the Code the Legislature has clearly and unequivocally stated that the information and records gathered by a hospital peer review committee are to remain confidential and not be subject to discovery through judicial subpoena. MCLA 333.20175(5); MCLA 333.21515. The Attorney General's investigative subpoena is not excepted.

Although the Attorney General's position is otherwise the hospital's duty to report to the Department "the relevant circumstances" with the grounds for its disciplinary action does not render the confidentiality provisions ambiguous. MCLA 333.20175(4). The subsection following (SS) 20175(4) clearly limits discovery by the Department to general findings and reasons for the hospital's decision to take disciplinary action against one of its staff members. MCLA 333.20175(5); *Bruce, supra* at 801-802. The *Bruce* court below aptly dispelled the Attorney General's suggestion that the Code is unclear on this subject.

> "[T]he provision upon which the Attorney General relies does not defeat the privilege created by §21515. It merely requires the hospital to explain, in general terms, the reason for its action. Had the legislature intended to provide that information collected by the hospital peer review committees be made available for departmental investigations, it would have expressly so provided as it did in §16244, MCL 333.16244.15 (16244), which provides that the physician/patient privilege does not apply with respect to investigatory proceedings. Since it has failed to do so, the Attorney General's claim must be rejected." *Bruce, supra* at 802.



The Attorney General's argument that his request for discovery is an exception to the Code's confidentiality provisions is further discredited in view of the very means by which the Attorney General seeks to compel disclosure of the information gathered by the hospital's review committee. Pursuant to the Attorney General's authority to subpoena under Article 15 of the Code, the Attorney General has attempted to utilize his investigative subpoena powers for the purpose of conducting a license review investigation under Article 15. MCLA 333.16235. The confidentiality provisions of Article 17, however, provide, without exception, that "the records, data and knowledge collected . . . are confidential . . . and are not subject to court subpoena." MCLA 333.21515; MCLA 333.20175(5). Furthermore, these provisions explicitly provide that the information which the Attorney General seeks to subpoena from the hospital reviewing committee is to be used *only* for proceedings conducted by the internal peer review committees of hospitals under Article 17. MCLA 333.20175(4); *Bruce, supra* at 801. The language of the statute is clear and unambiguous. The Attorney General's investigative subpoena issued by the trial court is invalid.

B. The Statutory Privilege Of Confidentiality Created For Peer Review Committee Communications Is Essential To A Hospital's Continued Efforts To Improve The Quality Of Care And Treatment Of Its Patients.

The Court of Appeals below discussed in detail the Legislature's rationale for assuring a hospital peer review committee that its investigative communications, reports and data would remain privileged and confidential.

> "It is readily apparent that the statutory privilege created with respect to peer review committee communications was intended to encourage those committees to conduct their proceedings in a frank and professional manner. By insuring that the proceedings remain confidential, the Legislature has provided strong incentive for hospitals to carry out their statutory duties in a meaningful fashion. In the absence of such protection, associates of those physicians being investigated by the hospital might prove to be much more reluctant to evaluate their colleagues' skills in an objective fashion. In the face of such reluctance, it is entirely conceivable that the information which is now produced as a result of the committee investigations, information which the department claims to be so necessary to its own investigations, *might not exist at all.* If that were the case, not only would the information be unavailable to the department, it would also be unavailable to the hospital and the protections of Article 17 would essentially be rendered meaningless." (Emphasis added) *Bruce, supra* at 803

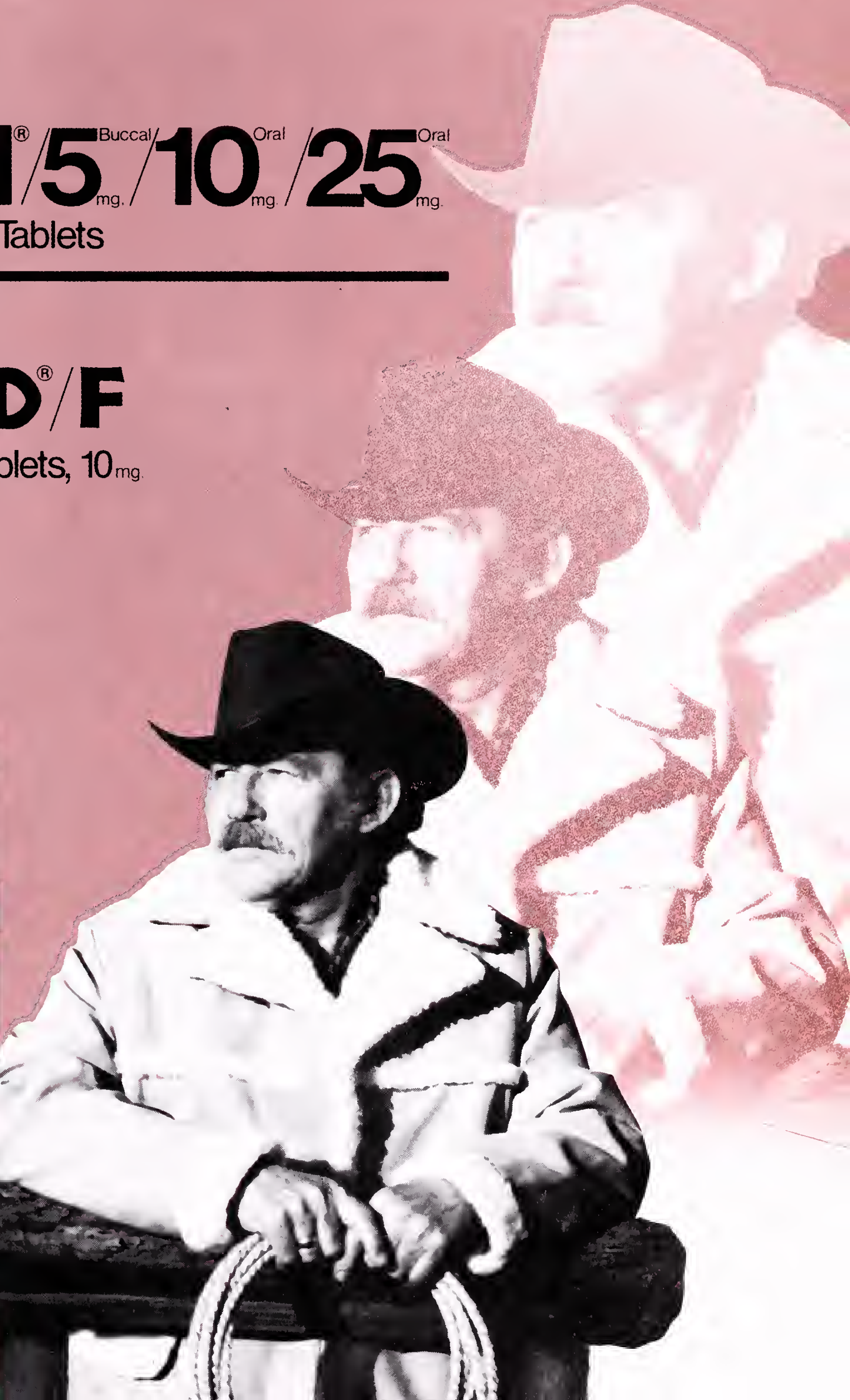
Continued on page 684

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, CA 90057

For Full Prescribing Information, Please See PDR. REFER TO PDR

Android® /5 mg. Buccal /10 mg. Oral /25 mg. Oral
Methyltestosterone U.S.P. Tablets

ANDROID®/F
Fluoxymesterone U.S.P. Tablets, 10 mg.



AMICUS CURIAE/Continued

(citation omitted).

See also Marchand v Henry Ford Hospital, 398 Mich 163, 167 (1976). Faced with evaluating similar statutory provisions which protect the confidentiality of peer review investigations, other state and federal courts have shared the same policy concerns of the appellate court below.

> "Confidentiality is essential to effective functioning of the staff meeting; and these meetings are essential to the continued improvement in the care and treatment of patients. Candid and conscientious evaluation of clinical practices is a *sine qua non* of adequate hospital care." *Bredice v Doctors Hospital, Inc,* 50 FRD 249, 250 (1970).

See also Mennes v South Chicago Community Hospital, 100 Ill App 3d 1029; 427 NE2d 952 (1981); *Matchett v Superior Court,* 40 Cal App 3d 623; 115 Cal Rptr 317 (1974); *Posey v District Court,* 196 Colo 396; 586 P2d 36(1978); *Texarkana Memorial Hospital v Jones,* 551 SW2d 33 (Tex, 1977); *Tucson Medical Center v Misevich,* 113 Arix 34; 545 P2d 958 (1976).

Despite the overwhelming public policy in favor of maintaining the privileged and confidential nature of peer review proceedings, the Attorney General asserts that the impediment to the Department's license review information presents an overriding public policy which should result in an exemption to the general rule.

The Attorney General, however, is not considering the full impact of the chilling effect which would occur if hospital peer review investigations were not conducted on a privileged and confidential basis. Physicians and medical staff members who sit on reviewing committees, and those individuals who contribute to this internal investigation, would not be as ready to come forward with damaging evidence concerning a fellow staff member knowing that the information could be used in a state licensing review investigation. The undesirable result would be fewer reports to the Department by hospitals of disciplinary action taken against staff members.

CONCLUSION

The Michigan Public Health Code clearly and unambiguously states that hospital peer review committee communications, data and records are to remain confidential and not subject to subpoena through the judicial process. The rationale for not allowing compelled disclosure of the information gathered by a hospital peer review committee is premised on the desire to maintain an uninhibited and candid atmosphere for peer review committee discussions in order to promote improvement in the care and treatment of hospital patients. Without the statutory privilege of confidentiality, statewide peer review programs would deteriorate along with the current effective methods of reviewing health care.

RELIEF REQUESTED

Based on the foregoing, Michigan State Medical Society respectfully requests that this Court affirm the decision of the Court of Appeals below.

Respectfully submitted,
KERR, RUSSELL AND WEBER
By: A. STEWART KERR (P15908)
/S/ LOUIS G. COREY (P34377)
Attorneys for Amicus Curiae
Michigan State Medical Society
August 30, 1984 ☐

Best Wishes
for a
Joyous
Holiday Season

WHY NOT THE BEST?

With so many life insurance companies in the marketplace today, sometimes it's difficult to choose the one that is best for you.

At American Physicians Life, we offer a comprehensive range of competitively priced insurance products designed with the successful professional in mind including an innovative universal life plan, individual and group term life coverages, qualified pension programs, high-yielding annuity plans, and attractive disability income programs.

APL is represented by the most knowledgeable and professional insurance agents in the industry in addition to being staffed by home office personnel who are dedicated to providing the quality of service a successful professional expects and deserves.

When you are thinking about life insurance protection or planning for a secure future, why not choose a company who understands your particular protection needs—why not choose the best?

AMERICAN PHYSICIANS LIFE

For all your life insurance needs.

A SUBSIDIARY OF PHYSICIANS INSURANCE COMPANY OF OHIO

By Judith Marr

What every physician should know about contracts

MSMS Executive Director Bruce W. Ambrose, far right, talks with Eugene Procknow, left, and Richard Statuto, center, both of the management consulting firm Touche Ross, Inc., during a break at the November 1 Contracting Conference in Lansing.

You've been in practice 15 years, building up a nice patient load in your community. You've been hearing about the new PPO forming with the local hospital, wondering whether its founders would invite you in.

Today, an offer to join, and a contract, have arrived in the mail. Is it a good contract? Is it a good thing for you? What will hapen to your practice and your patients should you sign?

Lucky for you, MSMS has help. The physicians who attended the November 1 MSMS Contracting Conference in Lansing got a big dose of that help.

To give you some idea of the help available at MSMS, Michigan Medicine presents the following synopses of the discussion at the Contracting Conference. Further information from the conference will be published in the January issue of *Michigan Medicine*.

MSMS Immediate Past President Donald K. Crandall, MD, Muskegon, led off the conference with a survey of the medical economic developments of recent years. This set the scene for the present situation in which physicians are being asked to sign contracts to deliver medical care.

Richard Robinson, JD, manager, California Medical Association Contract Evaluation/Negotiation Services Department, took participants step by step through the contract evaluation process.

Eugene Procknow, partner, Touche Ross financial consulting firm, discussed the financial implications of contracts. Monte Jahnke, JD, partner, MSMS legal counsel firm of Kerr, Russell and Weber, talked about the physician's responsibility in legally enforceable agreements. And Robert Weyhing III, partner in the law firm of Clark, Klein and Beaumont, presented the hospital perspective on contracts.

Here is a roundup of their remarks:

Donald K. Crandall, MD:

As we move into the 1980s, the dominant issue for physicians is contracts and how they affect the individual physician's practice.

"Most of us sat back and watched," said Doctor Crandall, "as HMOs slowly grew. HMOs now serve 30 to 35 percent of the population when offered by a company."

"With significant modifications in the benefit package," said Doctor Crandall, "we will see a high percent penetration of HMOs."

Doctor Crandall's prediction is that PPOs will grow like HMOs, but will reach the level of HMO penetration quicker, "as more people are comfortable with the concept now, including physicians.

"So the number of physicians under contracts will grow significantly," he said.

Doctor Crandall attributed the interest in such groups as HMOs, PPOs, EPAs and others to growing consumer awareness and desire of patients to be a part of their heath care. He also gave strong credit to the current "major awareness of health care costs."

"The bottom line," he said, "is that management is able to make significant cuts in its overhead except in health costs, so they have become a growing burden. There is a significant movement among businesspeople and consumers to move into the competitive marketplace.

Government is looking hard at its Medicaid costs, and will tackle Medicare costs, now that the elections are over, he predicted.

"We can look forward to significant government controls in the next few years," he said, "and we should be in a position to respond."

Why the growing PPO market?

There is great variety in utilization patterns and medical care costs by regions, Doctor Crandall pointed out, illustrating his point with comparisons between the I-75 corridor and Western Michigan.

"If people are concerned with where to go for cost effective medicine, they'll pick the groups which are more cost effective, and use less medical care. When people start looking for preferred providers, they will look for people with efficient records.

"That data is accumulating," he continued. "If you don't know where you stand, your insurance companies do. And you may not ever have the opportunity to look at a contract if you're outside the usual limits."

Doctor Crandall emphasized the multiple options ahead for physicians — to sign with HMOs, PPOs, and/or stay with fee for service.

"We may very well do all of these things," he said. "The point is, the answer no longer is yes or no. We will have to make multiple decisions."

He warned that contracting affects whom physicians associate with, whom they refer to, who is on the hospital staff.

"When you analyze a contract you have to analyze yourself first, to determine what kind of practice you want." he said. "Then you must analyze your opportunities, and, lastly, look at the contract."

"Your decisions should be based on facts, on careful analysis, on a knowledge of your options, and on whether the contemplated move feels right."

Richard Robinson:

Physicians need to understand, when they discuss PPOs, that the bottom line is that you are asked to sign a contract for the delivery of medical services.

"Thus, you have to understand the monumental legal ramifications to a contract," he said. "A contract is a series of legal promises.

"If you are thinking of signing a contract," he said, "here are some issues to consider:" (Robinson offered 101 questions to ask before signing a contract. They accompany this article.)

1) What resources are available to me for referrals?

"Typically, contracts say you can only refer to others in the PPO group, and this may forever change your referral patterns."

"I am concerned," said Robinson, "that restrictions on your referral patterns may have both economic and professional liability consequences.

"The patient can incur expenses if you refer to a non-contract physician, and then you have

Continued on page 688

One hundred and one questions to ask before signing a contract

25 questions to ask about the business entity

1. Is the business entity clearly identified?
2. Who owns and controls the business entity?
3. Who sits on the Board of Directors of the business entity?
4. Who are the principal officers of the business entity?
5. Does the business entity need to be licensed to conduct its business within the state?
6. Does the business entity transact business within the state under other names?
7. Has the business entity provided copies of certified and/or audited balance sheets and profit and loss statements for the past five years?
8. Is the business entity willing to disclose a list of contract physicians who may be used as references?
9. Is the business entity willing to disclose a list of employer groups and/or employee groups who are presently receiving health benefits as a result of a contractual relationship with the business entity?
10. Within what counties in the state does the business entity intend to contract with physicians?
11. Has the business entity provided copies of any and all contracts offered to physicians within the state?
12. Does the business entity carry professional liability insurance?
13. If the business entity carries professional liability insurance, does the professional liability insurance extend coverage to physicians under contract?
14. Does the business entity require contracting physicians to carry professional liability insurance?
15. Does the business entity require that the contract physician name the business entity as an insured on the physician's liability insurance policy?
16. Has the business entity provided the physician with a copy of any and all professional liability insurance policies covering the business entity?
17. Does the business entity subcontract for utilization review, peer review and/or related activities?
18. Does the business entity's professional liability insurance extend coverage to the activities of subcontractors?

Continued on page 688

CONTRACTS/Continued

breached your contract. If the contract causes you to breach your standard of care, you've got professional liability problems."

2) Do not sign contracts with "hold harmless" clauses which state that the provider agrees to hold harmless the PPO.

"Be sensitive," warned Robinson, "to the attitude of business entities in contracts to shift liability to you. These are attempts for you to indemnify the PPO. Malpractice policies do not extend to contractually assumed liability."

3) Watch for open-ended utilization review clauses.

These call for physicians to follow PPO utilization standards now "and as may exist in the future.

"Through these clauses, business entities intend to tell you how to practice medicine," he said.

Ask also who is doing the review and what are the protocols, he said. "Standards and protocols will be written to protect the company, not the physician, if not already established when you sign the contract."

4) What happens in case of the PPOs bankruptcy?

New developments show physicians being sued to give up claims paid 90 days before the PPO goes belly up, he said.

5) What is the turn-around time on claims?

"Less than two percent of contracts CMA has analyzed guarantee pay in a time certain," he said, "and most common language to such effect is absolutely unenforceable."

6) What is the termination clause?

"You need to understand the difference in terminating the contract relationship and terminating the physician/patient relationship. They are not always tied together in a contract."

7) What are the required amounts of professional liability insurance?

"Be sensitive when you read a contract. It may not make sense for you to be in a contract under which you reduce your fees, while having to increase your coverage."

8) Does the contract require arbitration?

"Many contracts require that disputes be resolved through arbitration, which is a very expensive process. Some contracts require that if you lose, you pay all expenses.

"And if you sign a contract to have all disputes go to arbitration," he continued, "for all practical purposes, you are precluded from going to litigation. I fear arbitration is going to be used to avoid claims.

"The relationship between hospitals and doctors is changing," said Robinson. "Hospitals are defining their own goals, and physicians are the objects of a well-planned marketing effort. The relationship is in flux."

For that reason, Robinson said, the California Medical Association has offered its contract analysis services.

"A contract for delivery of medical services from a physician only needs two parts, in my opinion," said Robinson. "That is a fee schedule and a reference to some existing, known, reputable utilization review service.

"When you analyze a contract, draw a line down the middle of a paper. On one side, list the physician's obligations and on the other, the business entity's obligations.

"You will find that the language on the physician side often is full of 'musts,' 'shalls' and 'wills'. On the business entity's side, the language more likely will be full of 'mays' and 'cans.'"

The purpose of the conference, emphasized MSMS Pesident Louis R. Zako, MD, Dearborn Heights, was to provide physicians with the tools to analyze any contract they might want to enter.

"I hope you will gain valuable information," said Doctor Zako. "But in the end, there must be good results for the patient. For that's the most important thing we're after."☐

---

101 QUESTIONS/Continued

19. Does the business entity require by contract that subcontractors maintain professional liability insurance?

20. Does the contract allow the business entity to assign the contract to other business entities?

21. In what other states is the business entity offering contracts to physicians?

22. Is the business entity offering contracts to hospitals within the state?

23. Does the business entity employ physicians within the state?

24. Does the business entity own, operate or manage free-standing treatment centers within the state?

25. Is the business entity presently a party to any professional liability litigation and/or dispute?

63 questions to ask about the contract

26. Are all the parties to the contract clearly identified by name?

27. Does the contract contain any blank spaces?

28. Under what circumstances can the physician terminate the contract?

29. How much advance notice is required for the physician to terminate the contract?

30. Does the contract attempt to incorporate by reference into the contract documents which the physician has not seen or reviewed?

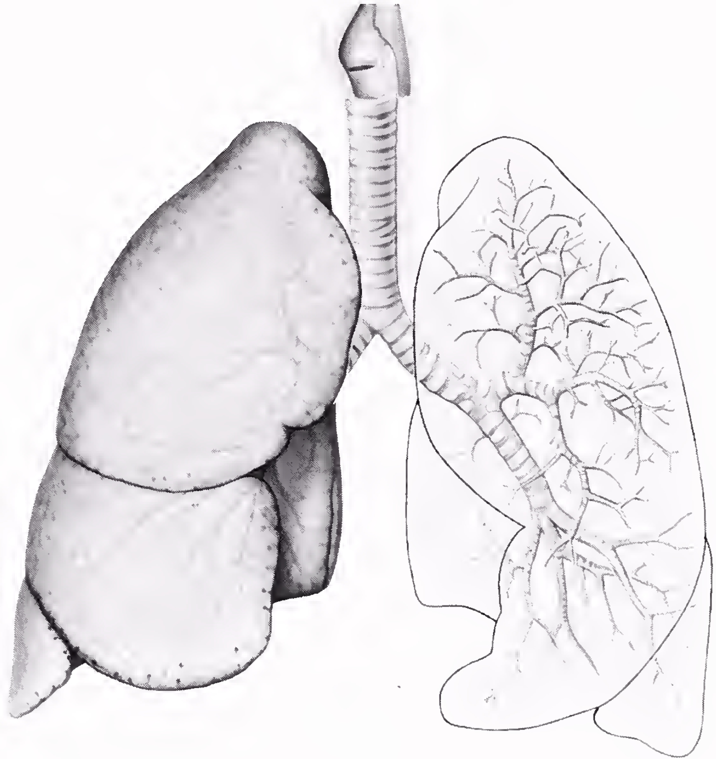
31. Does the contract require that the physician hold harmless and indemnify the business entity and/or any intermediary from any liability arising from the physician's rendering of professional services?

32. Does the contract require that the physician be solely responsible for the treatment of the patient?

33. Does the contract restrict the physician's traditional referral patterns by requiring that referrals be made only to contracting physicians and to contracting in-

Continued on page 690

Consider the causative organisms...



Ceclor®
cefaclor
250-mg Pulvules® t.i.d.

offers effectiveness against the major causes of bacterial bronchitis

H. influenzae, *H. influenzae*, *S. pneumoniae*, *S. pyogenes*
(ampicillin-susceptible) (ampicillin-resistant)

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile* Other causes of colitis should be ruled out.

Precautions. *General Precautions* — If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e g , pressor amines, antihistamines, or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor® (cefaclor, Lilly) There are, however, no adequate and well-controlled studies in pregnant women Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses Average levels were 0 18, 0 20, 0 21, and 0.16 mcg/ml at two, three, four, and five hours respectively Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70)

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200)

[061782R]

Note Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information

© 1984, ELI LILLY AND COMPANY

Lilly

400441

Additional information available to
the profession on request from
Eli Lilly and Company
Indianapolis, Indiana 46285

Eli Lilly Industries, Inc
Carolina, Puerto Rico 00630

stitutional providers?

34. Is the physician aware of the referral resources available under the contract?

35. Does the contract require that the physician maintain a specified dollar amount of professional liability insurance?

36. Does the contract contain an open-ended utilization review clause requiring the physician to follow unspecified review policies?

37. Does the contract allow for the contract to be unilaterally amended by the business entity without the agreement and/or assent of the physician?

38. Do all provisions in the contract relating to medical records comport with state law?

39. Does the contract require that a physician participate in peer review activities for the business entity?

40. Does traditional peer review immunity granted to physicians performing review functions on behalf of a medical society and/or hospital medical staff extend immunity to physicians who perform review for a business entity as a condition of a contractual relationship?

41. If the contract specifies that review functions will be performed by non-physicians, does the contract describe the professional qualifications required to be a review coordinator?

42. Does the contract require that each physician member of a partnership and/or a professional corporation execute the agreement?

43. Has the contract been reviewed by the physician's professional liability insurance company to determine whether the contract affects the physician's existing insurance coverage?

44. Does a contractual requirement that the physician submit to arbitration any contractual dispute and/or professional liability dispute affect the physician's existing professional liability insurance coverage?

45. To what extent does a contractual agreement to arbitrate disputes preclude the physician from pursuing a course of action through state court?

46. Does the contract automatically roll over from year to year without the physician indicating a willingness to continue the contractual relationship?

47. What impact does the termination of the contract have upon the physician/patient relationship?

48. Does the contract require tha the physician keep confidential any business entity documents?

49. Does the contract contain any contractual restrictions upon the physician's ability to practice medicine consistent with prevailing community standards of care?

50. Does the contract make vague reference to "practice cost effective medical and surgical care" and/or "innovative cost containment techniques"?

51. Has a representative of the business entity made any oral or written representation concerning the physician's contractual relationship which is not embodied in the wrtten contract?

52. Does the contract require that the physician notify patients of the physician's decision to terminate the contractual relationship?

53. If the contract contains a grievance procedure, does the contract fully explain all the steps and requirements of such a grievance procedure?

54. If the contract provides for a grievance committee, are members of the grievance committee appointed or elected?

55. Does the contract create financial obligations for the physician?

56. Does the contract limit referrals to "contract" laboratory and/or x-ray facilities?

57. Does the contract limit the physician's independent and professional judgment regarding the involvement of an assistant surgeon, anesthesiologist, etc.?

58. Does the contract limit the time for the submission of claims?

59. Does the contract provide for payment of claims to the physician within a specified time limit?

60. Does the contract provide for a penalty if payment to the physician is delayed?

61. Does the contract specifically provide that the agreement will be governed by state law?

62. Does the contract provide some readily available method of identifying patients under the contractual relationship?

63. Does the contract require that the physician call and verify patient information prior to each consultation?

64. Does the contract clearly define and specify non-covered services?

65. Does the contract provide that the patient is liabile for payment of non-covered services?

66. Does the contract allow the physician's name to be used on brochures, other advertising, radio and/or T.V.?

67. Has the physician reviewed carefully any and all documents referenced in the contract?

68. Does the contract require written and/or other prior authorization before the commencement of specified procedures?

69. Does the contract list the specific procedures which require prior authorization?

70. Does the contract provide for the physician to review prior authorization in a timely and reasonable manner?

71. Does the contract require the physician to modify existing office procedures and/or billing systems?

72. Does the contract require that the physician's status as a "contract" physician is conditioned upon the physician maintaining medical staff privileges at one or more contracting hospitals?

73. Does the contract obligate the physician to provide any services after the contract is terminated?

74. Does the contract allow for the fee schedule to be unilaterally changed without prior notice to the physician and/or without the prior assent of the physician?

Continued on page 694

Competence counts

Hurley Medical Center photo

In selecting a doctor, 74 percent of Americans consider competence, not cost.

Competent doctors remain the key to health. But competence isn't immunity to litigation.

Consider our competence – and our professional liability protection and strong-defense philosophy.

We defend you against non-meritorious claims. We won't settle a claim without your approval or merely to cut our defense cost.

PICOM
Physicians Insurance Company Of Michigan
4277 Okemos Rd., Box 1000
Okemos, Michigan 48864
(517) 349-6500
(313) 557-4845
1-800-292-1036

Lung cancer drug

A drug that may turn cancer cells back into normal cells is being tested for effectiveness in patients with cancers of the lung or head and neck at the University of Michigan and Veterans Administration Medical Centers. The drug, monomethylformamide, or NMF, belongs to the class of drugs known as polar solvents, which appear to be capable of turning malignant cells into normal cells.

"A key characteristic of cancer cells is an unrestrained ability to divide and multiply," Ronald Natale, MD, says. "Cells with such abilities are indifferentiated. The NMF seems to be able to make the cells differentiate, and stop dividing."

Doctor Natale cautions that this effect has been observed only in laboratory experiments. In his studies, patients receive NMF intravenously, once a day for five days. After four weeks, the patients return for another five-day treatment course. Before treatment courses are repeated, tumors are measured with X-rays or scans to determine whether any shrinkage may have been caused by the drug.

Colon cancer risk

Men with sedentary jobs have a greater risk of colon cancer than those whose jobs require a high level of activity, according to a study by researchers at the University of Southern California School of Medicine. The study suggests that physical inactivity, in general, plays a major, previously unrecognized role in colon cancer and that high levels of activity may aid in prevention.

The findings are based on an analysis of 2,950 colon cancer cases in males in Los Angeles County, representing a range of racial and socioeconomic groups. As part of their analysis, the USC researchers rated the activity level of patient occupations, grouping them into three categories — sedentary, moderate and high.

Overall, sedentary workers had a colon cancer risk at least 1.6 times that of high-activity workers. The risk increased in a stepwise manner as job activity decreased. The degree of risk varied further according to specific sections of the colon. The strongest relationships occurred in the descending colon — a major portion toward the end of the tract — where the cancer risk was nearly three times greater in the sedentary group than in the high-activity group.

Magnetic resonance system

A facility to house Michigan's second magnetic resonance system — a $2.5 million diagnostic and research project — is being built near the Michigan State University Clinical Center.

Known as the Clinical Magnetic Resonance (MR) Service, the new unit of MSU's Department of Radiology will use a General Electric Co. 1.5 Tesla whole-body imaging and spectroscopy system. Installation is expected by next July when patients will be accepted for MR diagnoses on a referral basis.

The radiology department is part of MSU's College of Human Medicine and College of Osteopathic Medicine.

Chestpain hotline

Borgess Medical Center, Kalamazoo, has established a new consumer service, the Chestpain Hotline.

The HOTLINE will save lives and decrease disability, according to a Borgess official, because HOTLINE callers will have a qualified assessment of their chest pain, and in turn, will seek medical help sooner.

The Chestpain Hotline number is (616) 383-8282. A toll-free number is planned but no availability date has been established.

New standards for blood banks

The American Association of Blood Banks has issued new blood banking standards with the publication of the 11th edition of its *Standards for Blood Banks and Transfusion Services*.

The latest edition of the *Standards* contains extensive modifications of content, and a new section on histocompatibility testing has been added. The sections on "Tests for Evidence of Serological Incompatibility" and on "Transfusion Complications" have been revised, and now also address protection of the public against AIDS and of newborns against cytomegalovirus infection.

Pediatric hospice program

Bay Valley Home Health Services, Inc. has been awarded grants from the Flint Area Health Foundation and Flint Junior League to establish a Pediatric Hospice Program.

The program will provide professional and volunteer service to terminally ill children in the home setting. Professionally directed separate support groups will be held for children, adolescents and parents who have suffered a significant loss. For information, call (313) 762-7500.

Neutron therapy

Harper Hospital will be the first in the world to have a specially designed and built compact superconducting neutron radiation therapy unit to improve cancer treatment.

The hospital has signed a contract with Michigan State University for a superconducting cyclotron. It will be the first such device in the world built specifically for the treatment of cancer. The cyclotron will bombard cancer cells with high-speed neutrons.

The $1.5 million cyclotron will be built by the National Science Foundation's National Superconducting Cyclotron Laboratory located at MSU. It will be installed in Harper's Radiation Oncology Center, which now treats cancer patients by radiation therapy. William E. Powers, MD, director of

More Newsfronts on page 694

LABORATORY OF CLINICAL MEDICINE

MID-MICHIGAN REFERENCE LABORATORY, II, Inc.
(517) 372-8180

1322 E. Michigan Ave.
Suite 211
Lansing, Michigan 48912

930 E. Mt. Hope Ave.
Lansing, Michigan 48910

2909 E. Grand River Ave.
Suite 104
Lansing, Michigan 48912

W. E. Maldonado, M.D.
Director

Robert B. Foy, Ph.D.
Chief Executive Officer

Kenneth W. Dobra, Ph.D
John W. Dyke, Ph.D
Dennis E. Freer, Ph.D.
John J. Gillespie, M.D.
Ronald N. Horowitz, M.D.
John R. Kateley, Ph.D.
Robert H. Knapp, M.D.

Barbara J. Leonard, M.D.
John G. Lyday, M.D.
Joseph R. Melvin, Ph.D.
Martin K. Oaks, Ph.D
Sandra K. Shirley, M.D.
Laurence R. Simson, Jr., M.D.
Susan M. Strate, M.D.

REFERENCE LABORATORY FOR SPECIALIZED PROCEDURES
Specimen Pickup and Delivery of Test Results Daily
House calls are available upon Physicians request
Assignment is accepted from Medicare, Medicaid, Blue Shield and all other insurance carriers.

Michigan Conference
on Maternal and
Perinatal Health
March 20-21, 1985
Hyatt Regency Dearborn
"Maternal/Perinatal Health:
A Delicate Balance"
For details: Michigan State Medical Society, P.O. Box 950, East Lansing, MI 48823 (517) 337-1351

the center, said the cyclotron will not replace other methods of treating cancer, but will be used to combat tumors that are predictably resistant to present forms of radiation.

Project USA

Project USA, an AMA program to supply physicians for short-term, general medicine assignments at Indian Health Services (IHS) and National Health Service Corps (NHSC) facilities, recently was awarded a three year contract by the Health Resources and Services Administration to continue providing this service.

Project USA, now in its eleventh year, has recruited physicians to practice in rural areas from Maine to California and Alaska to Florida.

The program provides replacements at IHS and NHSC hospitals and clinics so that the physicians at those locations can take brief leaves for vacation, continuing education, or other purposes.

Project USA physicians receive $500 a week, round trip coach air fare, housing and meals. Physicians interested in participating in this program are asked to contact John Naughton, AMA, 535 North Dearborn, Chicago, 60610; or call (312) 645-4702.

First-year oath

Taking the Hippocratic Oath (or a version of it) is traditional for new MDs graduating from medical school, but at Michigan State University's College of Human Medicine there's also an oath for students as they *begin* their medical training.

"A product of several authors, the oath has been in place since 1982 as a means of focusing student dedication on preparation for a rigorous and demanding profession," Dean W. Donald Weston, MD, said.

The oath emphasizes service to future patients, including a pledge to take on the study of medicine as a life-long responsibility

75. Does the contract limit the number of patients the physician may (or must) serve over the course of a year?

76. Does the contract require the physician to be available on a 24 hour basis?

77. Does the contract require that a "contract" physician arrange for another "contract" physician to cover during absences and vacations?

78. Does the contract refer to unspecified medical policies?

79. Does any party to the contract have the right to unilaterally change medical policies?

80. Does the contract provide an opportunity to examine the experience and qualifications of "contract" referral physicians?

81. Does the contract require the physician to accept all patients referred under the contractual relationship?

82. Does the contract require all non-physician entities which are parties to the contract to maintain a qualified medical director?

83. Does the contract limit the right of a physician to contract with any other third party?

84. Does the contract permit termination if the contractor becomes insolvent?

85. Does the contract place cost concerns ahead of quality concerns?

86. Does the contract unreasonably restrain the physician's ability to compete in the marketplace?

87. Does the contract specifically exclude from coverage services rendered by any recognized specialty?

88. Does the contract provide for a "gatekeeper" approach to the delivery of health care?

12 questions to ask about professional liability

89. Does the contract contain broadly worded indemnification clauses which attempt to shift risks from the business entity to the physician?

90. Does the physician's existing professional liability insurance cover any assumed contractual liability under the terms and conditions of the contract?

91. Does the contract directly or indirectly impair the physician's exercise of good medical judgment?

92. What is the name of the professional liability insurance company that insures the business entity?

93. Is the business entity's professional liability insurance "claims-made" or "occurrence" coverage?

94. Has the business entity allowed the physician an opportunity to request and review the business entity's professional liability insurance policy?

95. What is the extent of a "contract" physician's liability if the business entity is found liable on a theory of corporate negligence?

96. Does the business entity's professional liability insurance protect the physician from liability on charges of violation of antitrust laws?

97. Will the business entity provide a list of attorneys specializing in medical malpractice defense work who are customarily and regularly retained by the business entity to handle professional liability claims?

98. If the contract requires the physician to perform review functions outside the medical staff and/or medical society setting, how will the business entity establish standards, criteria and norms which will be used in this review process?

99. Does the business entity assume liability for utilization review decisions which are contrary to the attending physician's medical judgment?

100. Does the business entity screen applicant physicians in such a manner as to limit or reduce the possibility of corporate negligence?

101. Does the business entity carry sufficient insurance to cover business entity administrative mistakes or deficiencies which deny or limit care? ☐

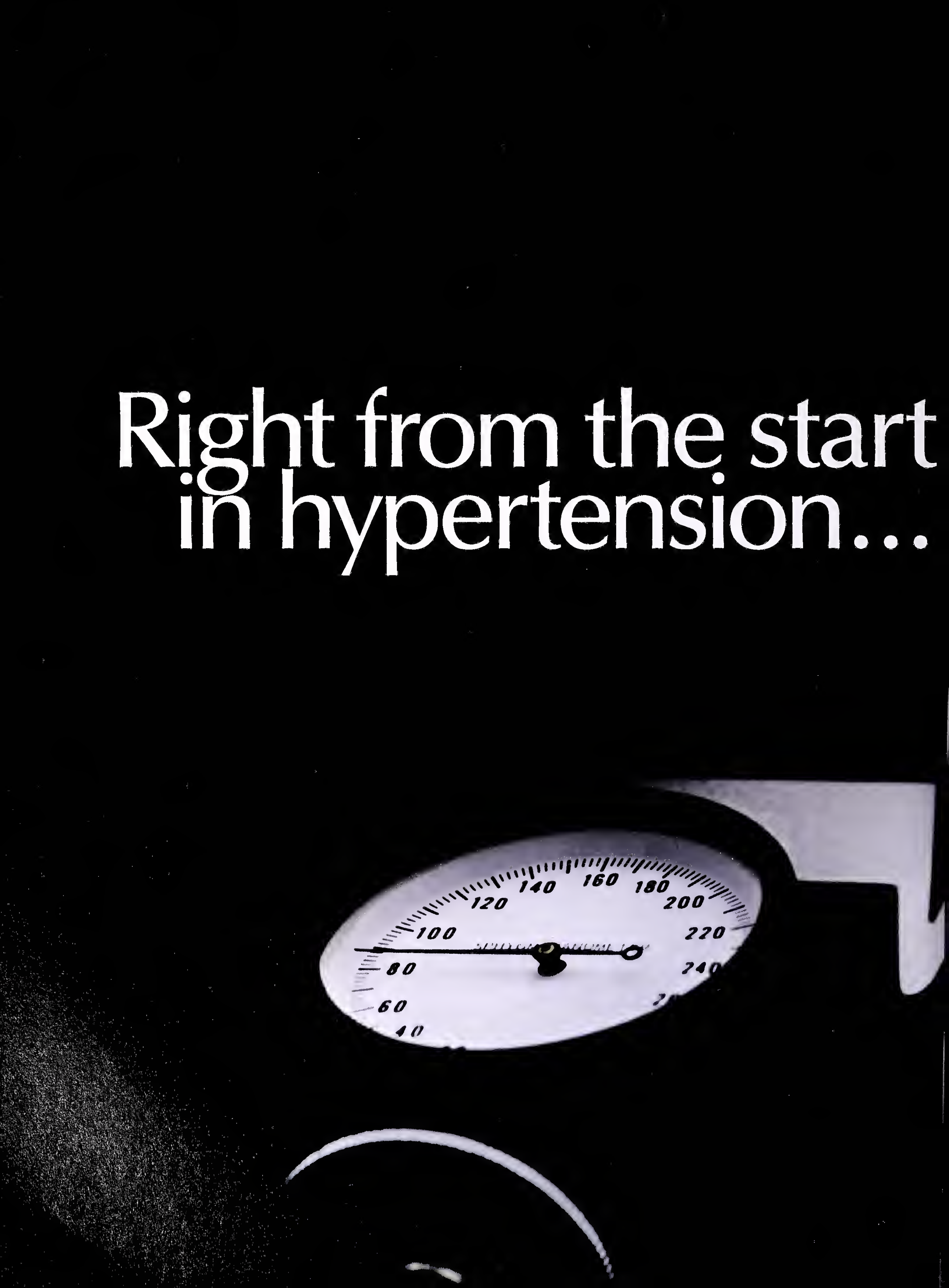
Copyright California Medical Association 1984

New studies uncover the potassium effects of beta-2 blockade

Clinical pharmacology data from *The New England Journal of Medicine:*

"...when normal young men are given infusions of epinephrine at levels such as those that circulate in patients with myocardial infarction, their serum potassium concentrations fall by about 0.8 [mmol] per liter. Hypokalemia is prevented by selective beta-2 blockade."[1]

Evidence that all beta blockers are not created equal.


Right from the start
in hypertension...
120
140
160
180
200
220
100
80
60
40

Once-daily INDERAL LA (propranolol HCl) for smooth blood pressure control without the potassium problems of diuretics

Once-daily INDERAL LA (propranolol HCl) avoids the risk of diuretic-induced ECG abnormalities due to hypokalemia.[2,3] In addition, INDERAL LA preserves potassium balance without additive agents or supplements while providing simple, well-tolerated therapy with broad cardiovascular benefits.

Once-daily INDERAL LA for the cardiovascular benefits of the world's leading beta blocker

Simply start with 80 mg once daily. Dosage may be increased to 120 mg to 160 mg once daily as needed to achieve additional control.

Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

For beta-1/beta-2 blockade

Once-daily
INDERAL LA
(PROPRANOLOL HCl [illegible]

AL LA
RAL LA
RAL LA

The appearance of these capsules is a registered trademark of Ayerst Laboratories.

80 mg 120 mg 160 mg

Please see brief summary of prescribing information on the next page for further details.

For beta-1/beta-2 blockade

Once-daily
INDERAL® LA
(PROPRANOLOL HCl) LONG ACTING CAPSULES

80 mg
120 mg
160 mg

The appearance of these capsules is a registered trademark of Ayerst Laboratories.

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

> IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

REFERENCES

1. Epstein FH, Rosa RM: Adrenergic control of serum potassium. *N Engl J Med* 1983; 309:1450-1451. **2.** Holland OB, Nixon JV, Kuhnert L: Diuretic-induced ventricular ectopic activity. *Am J Med* 1981;70:762-768. **3.** Holme I, Helgeland A, Hjermann I, et al: Treatment of mild hypertension with diuretics. The importance of ECG abnormalities in the Oslo study and in MRFIT. *JAMA* 1984;251:1298-1299.

9411/1184

Ayerst®
AYERST LABORATORIES
New York, N.Y. 10017

Copyright © 1984 AYERST LABORATORIES
Division of AMERICAN HOME PRODUCTS CORPORATION

BALANCED CALCIUM CHANNEL BLOCKADE!

CARDIZEM®
(diltiazem HCl)
balances potent coronary vasodilation with a low incidence of side effects

Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:

1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

Please see full prescribing information on following page.

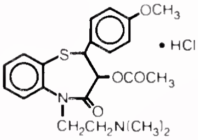
2/84

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral/LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy** — CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 4/1/84

Another patient benefit product from
PHARMACEUTICAL DIVISION
MARION
LABORATORIES, INC.
KANSAS CITY, MISSOURI 64137

By Betsy Moon

Kahkonen

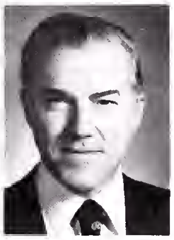
Farah

Dorothy Kahkonen, MD, Detroit, is the newest member of the Henry Ford Hospital board of trustees. Doctor Kahkonen of HFH's Division of Metabolic Disease was elected by the 450-member staff at the hospital. She has been with HFH since 1966 ... The Michigan Academy's candidate for the American Academy of Family Physicians board of directors is **Robert L. Vitu, MD,** Saginaw. Doctor Vitu is a past president of the Michigan Academy of Family Physicians ... **Ben S. Farah, MD,** recently was appointed to McLaren General Hospital's board of trustees. A native of Flint, Doctor Farah is the first MD ever to have been appointed to McLaren's board of trustees ... McLaren's Director of Emergency Medicine **Alan Morgan, MD**, Flint, was the featured speaker at a recent program on emergency medical care at the Genesee District Library Headquarters ... The Genesee County Medical Society recently produced a 30- minute talk show on eating disorders. Featured on the show was dermatologist **Stan Alfred, MD** ... **Richard Lam, MD,** Battle Creek, participated in the Bud Light Ironman Triathlon World Championships in Hawaii and placed 420th out of 904 finishers. Doctor Lam completed this event after swimming 2.4 miles, biking 112 miles, and running 26.2 miles ... The American Academy for Physical Medicine and Rehabilitation named **Myron M. LaBan, MD,** Detroit, its president-elect at its 46th Annual Assembly in Boston ... The American College of Obstetricians and Gynecologists has elected **Asghar Afsari, MD,** West Bloomfield, treasurer of District V. Doctor Afsari will serve a three year term ... **Alexander Walt, MD,** Huntington Woods, and **Robert Wilson, MD,** Grosse Pointe Farms, were coordinators of the Trauma Symposium held at Harper Hospital November 9 and 10. Sponsoring the program were Wayne State University School of Medicine, the Michigan Committee on Trauma, and the American College of Surgeons ... **Eugenia E. Gurskis, MD,** Detroit, retired in November to Union Lake, Michigan. Doctor Gurskis specialized in Obstetrics and Gynecology and was affiliated with the Women's Hospital in Detroit ... **David R. Rovner, MD,** a faculty member of the College of Human Medicine at Michigan State University, was presented with the 1984 Distinguished Faculty Award. Doctor Rovner is a Professor of Medicine and Chief in the Division of Endocrinology and Metabolism at MSU ... **Howard Brody, MD, PhD,** of Michigan State University's College of Human Medicine received the MSU Teacher-Scholar Award of 1984 ... **Emanuel Hackel, MD,** professor at Michigan State University, has been elected to the board of directors of the American Association of Blood Banks ... **Alfred B. Swanson, MD,** has been elected president of the International Federation of Societies for Surgery of the Hand. The organization includes 30 national and regional societies from 79 countries ... The American Association of Women Radiologists elected **Kay H. Vydareny, MD,** Grand Rapids, president of the association. The AAWR is a 400-member national organization ... **Mark W. Hinshau, MD,** Grand Rapids, is president-elect through 1985 of the Michigan Council of Child Psychiatry ... **Arthur S. Elstein, MD,** East Lansing, is serving a four-year term on the Board of Directors of the National Board of Medical Examiners as member-at-large ... **David B. Kaufman, MD,** East Lansing, is a member of the Scientific Advisory Board of the National Kidney Foundation ... **Harold E. Bowman, MD,** East Lansing, has been re-elected to the executive committee of the American Cancer Society's board of directors. He also was re-elected to the ACS's medical and scientific executive committee ... **Richard C. Honicky, MD,** East Lansing, is vice-chairman of the Section of Pediatrics of the American College of Chest Physicians ... **Helga V. Toriello, MD,** serves on the information and education committee of the American Society of Human Genetics. She is also a member of the editiorial review board of *Spina Bifida Therapy* ... **Kenneth Vanderkolk, MD,** East Lansing, recently was installed as president of the Central Association for Obstetricians and Gynecologists. The members of this association are elected practioners who are active in teaching, patient care, and research ...

... **Fazlolah Nickhah, MD,** Ypsilanti, was apppointed and served as medical officer of the Twenty Third Olympiad in Los Angeles. Doctor Nickhah is past president of the Midwest Chapter of the American College of Sports Medicine, a member of the International Association of Olympic Medical Officers, and of the Medical Commission of International Amateur Wrestling Federation. He was five times boxing champion of Iran, recipient of two gold medals, and he represented Iran in boxing in the 1952 Olympic Games in Helsinki. He has served as medical officer and delegate in five Olympic Games and in twelve World Wrestling Championships as team physician. Doctor Nickhah ran a fifty mile race in Chicago in 1980, to celebrate his fiftieth birthday, finishing 111th overall and sixth place in his age group. He is a recipient of three gold medals in the Senior Olympics in boxing. ☐

Vydareny

Nickhah


Vanderkolk

Betsy Moon, Plymouth, is an intern with the MSMS Department of Communications and Professional Relations. She is a senior in Communications at Michigan State University.

Robert M. Smith, MD
Traverse City

Robert Smith, MD, died September 19 at the age of 39. Doctor Smith graduated from the University of Michigan in 1971. He served his internship at the Malcolm Grow U.S. Air Force Medical Center at Andrews Air Force Base in 1971-72. Doctor Smith was completing postgraduate work in aerospace medicine.

Robert E. Reagan, MD
Benton Harbor

Robert E. Reagan, MD died September 29, 1984. He was 85. Doctor Reagan graduated in 1930 from the University of Illinois. His specialty was surgery and he was affiliated with Mercy Hospital, Benton Harbor General, Memorial Hospital, and St. Joseph. Doctor Reagan served as a commander in the medical military from 1942 to 1945. He was also chairman of the Public Relations Committee of the Berrien County Medical Society.

Fanny H. Kenyon, MD
Lansing

Fanny H. Kenyon, MD, died on November 1 at the age of 92. She graduated from Wayne State University in 1935. Doctor Kenyon was listed in Who's Who in American Women and was president of the local and state Business and Professional Women's Clubs. She was chairperson of the National Health and Safety Commission.

Robert C. Dickerman, MD
Grosse Pointe

Robert C. Dickerman, MD, died July 23 at the age of 58. Doctor Dickerman graduated from Creighton University College of Medicine in 1952. His specialty was pathology and he was affiliated with Detroit Memorial, Cottage Hospital of Grosse Pointe, and Detroit Receiving Hospital.

Doctor Fochtman wins MSMS Plessner Award

Michigan State Medical Society

In 1979 MSMS received a bequest of $50,000 from the estate of Frederick K.M. Plessner with the stipulation that the funds be used to bestow "The Frederick and Besse Moulton Plessner Memorial Award" and a $5,000 gift to the physician who "best exemplifies the practice and ethics of a rural country practitioner." This year Thomas W. Fochtman, MD, Sparta, above right, was named recipient of the Plessner Award by his peers. MSMS Board Chairman Thomas Berglund made the presentation. Doctor Fochtman's patients agree that he is most deserving of the award. One wrote, "I know of his kindness and his patience with the elderly, his compassion for the homesickness of a young Vietnamese mother, and his long hours of dedication to his profession. . . . His Christian ethics have made him respected and loved by all of us who know him."

Statement of ownership, management and circulation

Statement required by the Act of October 23, 1962; Section 4369, Title 39 of the United States Code showing the Ownership, Management, and Circulation of *Michigan Medicine*, published five times per month, 60 issues, mailed at East Lansing, Michigan and additional post offices in Ingham County for December 1, 1984.

1. The office of the publisher is located at 120 West Saginaw Street, East Lansing, Michigan 48823.

2. The general business office of the publisher is located at 120 West Saginaw Street, East Lansing, Michigan 48823.

3. The publisher is the Michigan State Medical Society. The editor is Judith E. Marr, 120 West Saginaw Street, East Lansing, Michigan 48823.

4. The owner is the Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823.

5. The known bondholders, mortgagees and other holders owning or holding one percent or more of total amount of bonds, mortgages or other securities are: None.

6. A. The total number of copies printed averages 10,238 per issue with a single issue nearest to filing date accounting for 10,327 copies.
   B. Paid circulation 9,780 subscriptions by mail, these being the active members of the Michigan State Medical Society, and others who receive subscriptions.
   C. Sales to dealers, number none.
   D. Free distribution by mail carrier or other means: 438.
   E. Total number of copies distributed: 10,327.

I certify that the statements made by me above are correct and complete.

Wellman Press, Inc.
For the Publisher

Michigan DOCTORS POLITICAL ACTION COMMITTEE

MDPAC *needs* your financial support in order to contribute to the campaigns of candidates responsive to the concerns of the medical profession. It is in the political arena that the major decisions affecting the medical profession are being made. Make a professional membership investment in

MDPAC

Michigan Doctors Political Action Committee

An MDPAC investment:

- Reflects physician commitment to political action and results
- Represents a large physician "precinct" motivated to influence the political and legislative processes that affect the practice of medicine
- Provides a coordinated means for medicine to support candidates who recognize and promote the aims of the medical profession

MDPAC Regular membership	$ 50.00
MDPAC Sustaining membership	$150.00

(All sustainers receive an MDPAC sustainer pin)

MDPAC contributions should be written on a personal check

MDPAC, P.O. Box 769, East Lansing, MI 48823
Thomas E. Stone, MD, Chairman, MDPAC

By Judith Marr, Editor
and Thomas White

Michigan Attorney General Frank Kelley was one of twelve speakers to address members and other interested persons at the MSMS Public Affairs/Leadership Conference in October.

Board of Medicine activity and liability among Leadership Conference topics

There is a strong link between the professions of law and medicine, declared Attorney General Frank Kelley at the MSMS Public Affairs/Leadership Conference October 25.

"That link is the public trust we both share," said Kelley, who has been Michigan Attorney General for 24 years and has served as president of the National Association of Attorneys General.

He spoke to approximately 250 physicians, spouses, MSMS staff members and other interested persons gathered for the conference in Lansing.

"Before we hold ourselves out to the public, we first must establish confidence and competence" he said.

Mr. Kelley noted that physicians are the only professionals to whom state law gives proprietary interest in their licenses. The law recognizes that physicians' licenses are earned through dedication, work and reputation.

"Thus, before they can be taken away," he said, "you have certain rights. Anyone who takes action against you has the burden of proving their charge. They must give you complete due process."

Complaint procedure

Generally speaking, he said, the complaint procedure against a physician takes this course:

1) Initial accusation is made;

2) Investigation, usually by the Department of Licensing and Regulation;

3) A formal complaint is filed by the Attorney General, if warrented;

4) A compliance conference is held; and

5) A formal hearing with counsel, discovery and cross examination is held.

The hearing procedure, he said, conforms to the Administrative Procedures Act, and assures due process.

Physicians are the only group for which the hearing officer does not make a decision. The officer, instead, makes findings of fact

---

Mr. White is chief of the MSMS Section on Hospital/Physician Relations.

and conclusions of law, then the Board of Medicine decides what action, if any, should be taken. The Board of Medicine bases its decisions on the preponderance of evidence as understood by an ordinary person. Its final order is subject to the review of the courts.

Since Jan. 1, 1981, when hearing rules were promulgated under the new Public Health Code, 114 complaints have been filed against physicians, reported Kelley. More than half of the cases, he said, were related to drugs or Medicare/Medicaid problems.

In the past three years the Board of Medicine has summarily suspended 21 physicians and suspended the licenses of 25.

"This is a more than conservative record," observed Kelley.

New Trend

We are seeing a new trend in Michigan, said Kelley, of disciplining errant physicians more, but punishing them less.

"I hope you will put a stop to it," he said. "The professions have a serious responsibility not to abuse the privileges given them".

"Our history shows we have succeeded in having good government and more freedom than under any other government," he concluded. "Are we capable of maintaining it? We share an obligation to uphold the public trust."

During a panel discussion following Kelley's talk, Department of Licensing and Regulation Attorney Gay Hardy emphasized that the Board's primary responsibility is to the public.

"One of the problems we've had in reaching across the line to help identify and rehabilitate good physicians has been financial," she said.

Additional staff

The Bureau of Health Services finally is adding three investigators to its current six, which must do the work of researching the allegations made to all 13 regulatory boards working in the Department of Licensing and Regulation.

"If we can get more money, we can beef up our investigators and put them where the problems are," said Ms. Hardy. "The department also considers it is very important that we have a full-time consultant, an MD, to work with the Board on problems of impaired physicians, continuing competency questions, and foreign medical graduates' issues.

Board Chairman James L. Fenton, MD, Bay City, said the Board receives complaints against physicians from attorneys, the Michigan Insurance Bureau, patients, patients' families, medical societies, and other physicians.

Four panelists fielded questions on the Board of Medicine's purpose and function. The panelists, left to right, are MSMS legal counsel A. Stewart Kerr; Michigan Department of Licensing and Regulation Director Elizabeth Howe; L and R Attorney Gay Hardy, and Board Chairman James Fenton, MD.

Hospitals across the state notify the Board of any disciplinary actions they take against physicians.

Elizabeth A. Howe, director, Michigan Department of Licensing and Regulation, gave the Board of Medicine high marks for effectiveness.

Doctor Fenton, however, described the Board's frustration in doing its work under a very limited budget and with very limited personnel.

Seven years ago, when he joined the Board, he said, there were 14,000 licensed physicians in the state as opposed to 20,000 today, and the Board had 20 percent more funds.

"You ask me if we feel frustrated? I'd like to have you take care of 50 percent more physicians on 20 percent less money. You talk about a tough job!"

There are things MSMS members can do, individually and in committees, said the panel members, to help the Board of Medicine do its job.

Ms. Hardy called for MSMS to educate its members in terms of what the Board does and the rules it promulgates governing physicians' conduct. "MSMS has been most helpful in assisting the Attorney General's office, particularly in the difficult cases involving minimum standards of care," she said.

Hands-on solutions

Director Howe called for a continuation of the public/private partnership she has witnessed between MSMS and her department since she assumed its top position in January, 1983. She advocated a joint search for hands-on, rather than bureaucratic solutions to problems, as well as a forward-thinking approach.

Doctor Fenton asked MSMS to continue to help nominate candidates to fill Board positions, to support lobbying efforts to get Board rules passed, to supply expert witnesses for hearings and a list of physicians willing to give mental and physician exams to physicians brought before the Board.

Continued on page 706

From One of the
Oldest Medical Computer
Companies in Michigan

COMPLETE MEDICAL OFFICE COMPUTER DESIGNED FOR MICHIGAN PHYSICIANS

$6300

Includes

- IBM PC XT
- Program
- Training Class

Call or Write Today

Bennethum Computer Systems, Inc.
31811 Middlebelt Rd.
Suite 202
Farmington Hills, MI 48018
313/851-3058

— Since 1968 —

Professor O'Connell said no-fault malpractice insurance could be an alternative to the current litiginous situation.

No-fault insurance

Jeffrey O'Connell, professor at the University of Virginia School of Law, and co-developer of no-fault automobile insurance, addressed the subject of professional liability. A major portion of malpractice costs, he said, are litigation expenses.

A way to reduce the overall cost of malpractice insurance is by using a no-fault approach to handling malpractice claims, he suggested. Under a no-fault approach, patients who incurred an injury would, after verification of the injury, be automatically offered a predetermined settlement regardless of where the fault for the cause of the injury lay. In other words, the insurance company would create a set of criteria to identify situations in which it automatically would offer the patient a settlement.

The "beauty" of this approach, according to O'Connell, is that because the criteria for triggering a settlement offer are established prior to any compensable event, and because the offer will be made every time the event occurs, no admission of culpability can be inferred from the presentation of the offer. As well, the injured party would be given a limited amount of time, say 90 days from the date on which a settlement was offered, within which to accept or reject the tender. If the victim accepts the settlement he/she signs a statement waiving the right to pursue a claim in tort.

Award limits

O'Connell suggested that the amount of the settlement be limited to the net economic loss, including medical expenses and wage loss (the latter with a cap of something like $300 a week) beyond the victim's own collateral sources such as health insurance, sick leave, etc. Benefits would be paid month by month as loss accrues. No compensation would be offered for pain and suffering. O'Connell suggested that any victim's attorney who advised or persuaded his/her client against accepting a no-fault settlement would be at risk if the client pursued the claim in tort and came up empty-handed.

The waiver against pursuit of a claim in tort could be extended beyond the physician or provider to other potential plaintiffs such as manufacturers of surgical tools. In this way the risk and costs could be spread further. Establishment of "who pays what" could be determined in an inexpensive arbitration proceeding after the victim accepted the tender.

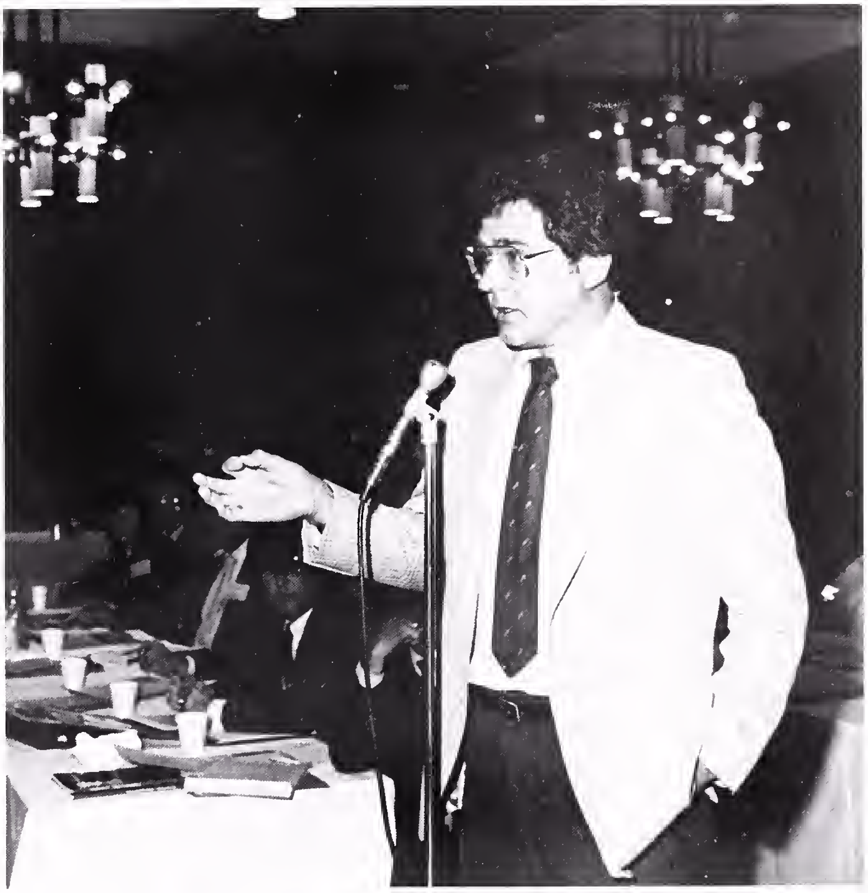
There are two ways to initiate a no-fault malpractice system: legislatively or through a contractual approach. On the national level, legislation currently is being proposed, which would provide incentives for states to adopt model state legislation for a no-fault system. The AMA has opposed this legislation on the basis that the malpractice insurance problem is different in each state and should not be addressed with the broad brush of federal legislation.

According to O'Connell, a contractual approach could be taken in the absence of legislation but with the approval of the state's insurance commissioner. The contractual approach enables the insurer to craft a no-fault contract for a very specific set of circumstances which the insurer finds are actuarially sound. Thus, the contractual approach provides more flexibility and control for the insurer than would exist if no-fault malpractice were addressed statuatorily.

Not a panacea

O'Connell concluded that no-fault medical malpractice is not a panacea for the ills of the current system, but it is perhaps a beginning, and a part of a total solution. In particular, it is not likely to address the problems of small claims (under $30,000) which may make up 80 percent of the monies paid out by an insurer.

An insurance company can review claims paid for a particular injury and do an analysis on whether the no-fault approach would be efficient, O'Connell said. Any action on the no-fault approach would be purely experimental, he stressed, and would take place under very narrow and controlled conditions.☐



A conference participant makes his point during a question-and-answer session.

We've been defending doctors since these were the state of the art.

These instruments were the best available at the turn of the century. So was our professional liability coverage for doctors. In fact, we pioneered the concept of professional protection in 1899 and have been providing this important service exclusively to doctors ever since.

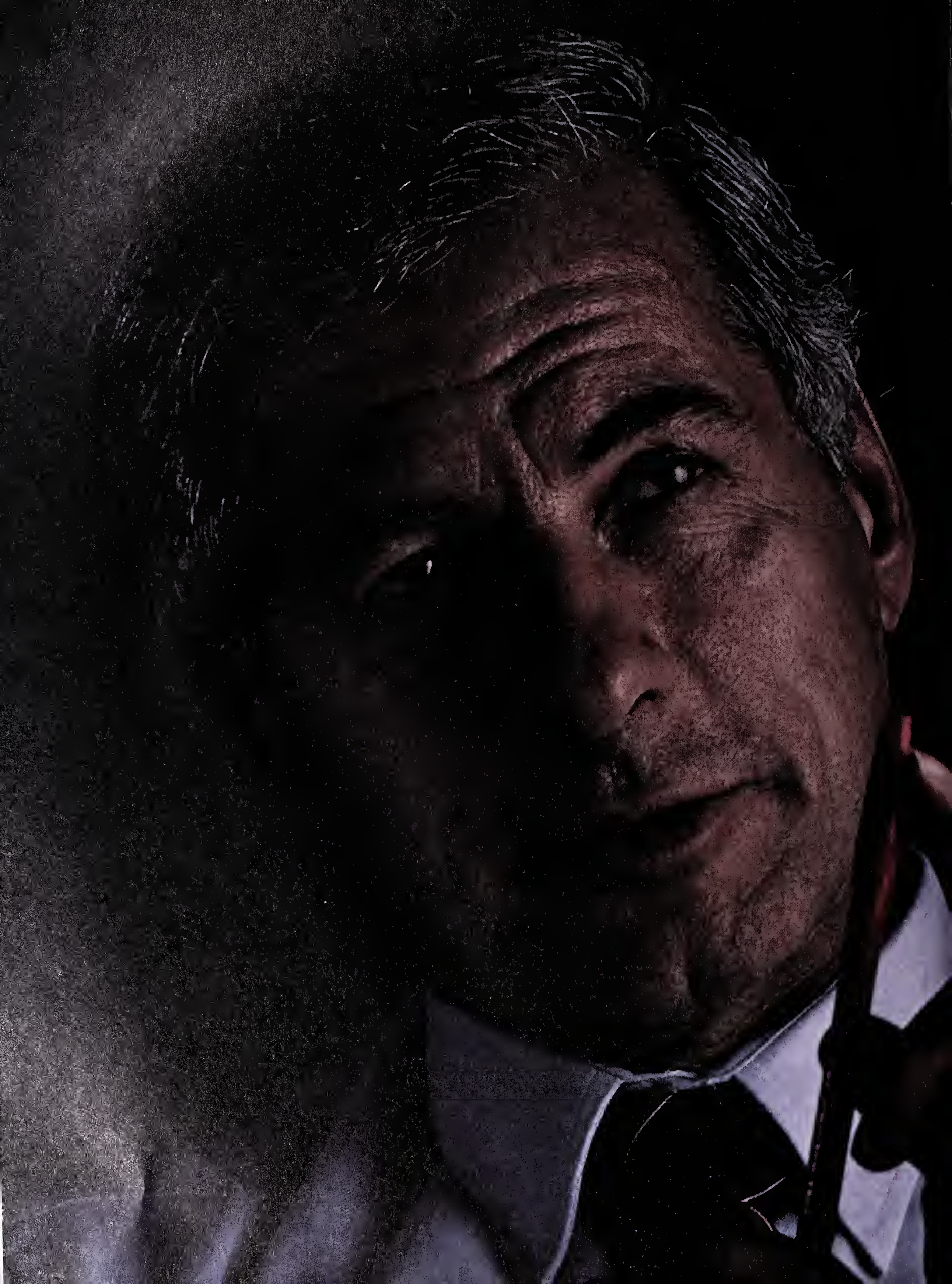
You can be sure we'll always offer the most complete professional liability coverage you can carry. Plus the personal attention and claims prevention assistance you deserve.

For more information about Medical Protective coverage, contact your Medical Protective Company general agent. He's here to serve you.

Turn of the century trephine for cranial surgery and tonsillotome for removing tonsils.

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

John K. Galloway, Thomas A. Weisman, Wayne M. Backus, Charles J. Rowe, Mark A. Whitman
6785 Telegraph Road, Suite 350, Birmingham, Michigan 48010, 313/647-6640
George J. Haworth, 2600 Five Mile Road, NE, Suite 101, Grand Rapids, Michigan 49505, 616/361-0863



“When the Ayerst rep told me
it costs about 45¢ a day,
I said you can stop right there.”

Most doctors are pleasantly surprised to learn that the average cost of daily therapy with the world’s most widely used beta blocker is so little, not much more than the cost of a daily newspaper.

When it’s INDERAL tablets (propranolol hydrochloride) you want for your hypertension patients, remember to specify Dispense As Written (DAW) or Do Not Substitute on your prescriptions. That way, you can always be assured they’ll get INDERAL®.

Please see next page for brief summary of prescribing information.

INDERAL®
(PROPRANOLOL HCl)
Small price to pay.

"When the Ayerst rep told me it costs about 45¢ a day, I said you can stop right there."

INDERAL® TABLETS
(PROPRANOLOL HCl)

10 mg 20 mg 40 mg 60 mg 80 mg 90 mg*

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

INDERAL® (propranolol hydrochloride) Tablets

CLINICAL PHARMACOLOGY

The Beta-Blocker Heart Attack Trial (BHAT) was a National Heart, Lung and Blood Institute-sponsored multicenter, randomized, double-blind placebo-controlled trial conducted in 31 U.S. centers (plus one in Canada) in 3,837 persons without history of severe congestive heart failure or presence of recent heart failure; certain conduction defects; angina since infarction, who had survived the acute phase of myocardial infarction. Propranolol was administered at either 60 or 80 mg t.i.d. based on blood levels achieved during an initial trial of 40 mg t.i.d. Therapy with INDERAL, begun 5-21 days following infarction, was shown to reduce overall mortality up to 39 months, the longest period of follow-up. This was primarily attributable to a reduction in cardiovascular mortality. The protective effect of INDERAL was consistent regardless of age, sex or site of infarction. Compared to placebo, total mortality was reduced 39% at 12 months and 26% over an average follow-up period of 25 months. The Norwegian Multicenter Trial in which propranolol was administered at 40 mg q.i.d. gave overall results which support the findings in the BHAT.

Although the clinical trials used either t.i.d. or q.i.d. dosing, clinical, pharmacologic and pharmacokinetic data provide a reasonable basis for concluding that b.i.d. dosing with propranolol should be adequate in the treatment of post-infarction patients.

CLINICAL: In the BHAT, patients on INDERAL were prescribed either 180 mg/day (82% of patients) or 240 mg/day (18% of patients). Patients were instructed to take the medication 3 times a day at mealtimes. This dosing schedule would result in an overnight dosing interval of 12 to 14 hours which is similar to the dosing interval for a b.i.d. regimen. In addition, blood samples were drawn at various times and analyzed for propranolol. When the patients were grouped into tertiles based on the blood levels observed and the mortality in the upper and lower tertiles were compared, there was no evidence that blood levels affected mortality.

PHARMACOLOGIC: Studies in normal volunteers have shown that a 90 mg b.i.d. regimen maintains beta blockade at, or above, the minimum for 60 mg t.i.d. dosing for 24 hours even though differences occurred at two time intervals. At 10-12 hours after the first dose of the day, t.i.d. dosing gave more beta blockade than b.i.d. dosing; at 20-24 hours the trend of the relationship was reversed. These relationships were similar in direction to those observed for plasma propranolol levels (see Pharmacokinetic).

PHARMACOKINETIC: A bioavailability study in normal volunteers showed that the blood levels produced by 180 mg/day given b.i.d. are below those provided by the same daily dosage given t.i.d. at 10-12 hours after the first dose of the day but above those of a t.i.d. regimen at 20-24 hours. However, the blood levels produced by b.i.d. dosing were always equivalent to or above the minimum for t.i.d. dosing throughout the 24 hours. In addition, the mean AUC on the fourth day for the b.i.d. regimen was about 17% greater than for the t.i.d. regimen (1,194 vs. 1,024 ng/ml·hr).

CONTRAINDICATIONS

INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS

CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL (propranolol hydrochloride) should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL, like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS

General: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

*The appearance of INDERAL tablets is a registered trademark of Ayerst Laboratories.

9371/1184

Ayerst®
AYERST LABORATORIES
New York, N.Y. 10017

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, (517) 337-1351.

Date: January 12, 1985, Primary Care Medicine: An Exciting Frontier Revisited. Location: Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit, 48202 (313) 876-3073. **Approved for:** 6.25 hours of Category I Credit.

Date: Mondays beginning January 14 through April 1, 1985, Regional Anatomy Course: Back and Limbs. Location: Room 108, Basement, Gordon H. Scott Hall of Basic Medical Sciences, 540 E. Canfield. **Sponsor:** Wayne State University School of Medicine. **For:** Directors of Medical Education/Chief Residents/Interested Physicians/Interested Dentists. **Cost:** $250.00 except for resident physicians enrolled in WSU Affiliated Hospital Program for whom fee is $150.00. **Contact:** Division of Continuing Medical Education, University Health Center 4-H, 4201 St. Antoine, Detroit 48201. **Approved for:** 24 hours of Category I Credit.

Date: Wednesdays beginning January 16 through April 3, 1985, Regional Anatomy Course: Thorax, Abdomen & Pelvis. Location: Room 108, Basement, Gordon H. Scott Hall of Basic Medical Sciences, 540 E. Canfield. **Sponsor:** Wayne State University School of Medicine. **For:** Directors of Medical Education/Chief Residents/Interested Physicians/Interested Dentists. **Cost:** $250.00 except for resident physicians enrolled in WSU Affiliated Hospital Program for whom fee is $150.00. **Contact:** Division of Continuing Medical Education, University Health Center 4-H, 4201 St. Antoine, Detroit 48201. **Approved for:** 24 hours of Category I Credit.

Date: Fridays beginning January 18 through April 5, 1985, Regional Anatomy Course: Head and Neck. Location: Room 108, Basement, Gordon H. Scott Hall of Basic Medical Sciences, 540 E. Canfield. **Sponsor:** Wayne State University School of Medicine. **For:** Directors of Medical Education/Chief Residents/Interested Physicians/Interested Dentists. **Cost:** $250.00 except for resident physicians enrolled in WSU Affiliated Hospital Program for whom fee is $150.00. **Contact:** Division of Continuing Medical Education, University Health Center 4-H, 4201 St. Antoine, Detroit 48201. **Approved for:** 24 hours of Category I Credit.

Date: January 27-February 1, 1985, Ninth Annual Midwinter Family Practice Update. Location: Boyne Highlands, Harbor Springs, Michigan. **Sponsor:** Office of Continuing Medical Education of the University of Michigan Medical School. **Cost:** $295 Physician Fee. **Contact:**Betty Phillips, Office of Continuing Medical Education, The University of Michigan Medical School, Towsley Center, Box 057, Ann Arbor, 48109-0010, PH. (313) 763-1400. **Approved for:** 20 ACCME Category I Credit Hours.

Date: January 27-February 1, 1985, Schuss Mountain Conference on Emergencies in Medicine. Locaton: Schuss Mountain, Mancelona. **Sponsor** Wayne State University, Department of Surgery, and Michigan Committee on Trauma. **Contact:** Theresa Sokol, Wayne State University Department of Surgery, 6-C UHC, 4201 St. Antoine, Detroit, 48201 (313) 577-5009. **Approved for:** 25 hours of Category I Credit.

Date: February 4-6, 1985, Hemodynamic Monitoring VII. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, Ann Arbor 48109 (313) 763-1400. **Approved for:** 14.5 hours of Category I Credit.

Date: February 9, 1985, Problems in Coagulation: The Clinical Pathologist as Consultant. Location: Burkei Auditorium of Henry Ford Hospital, Detroit, Michigan. **Sponsor:** Michigan Society of Pathologists. **Contact:** Dr. Kenneth McClatchey, Department of Pathology, University of Michigan, Ann Arbor 48109 **Approved for:** 3 hours of Category I Credit.

Date: February 27, 1985, Cardiology-Update. Location: St. John Hospital. **Sponsor:** CME Committee of St. John Hospital. **For:** Interested physicians. **Cost:** $90.00. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road, Detroit 48236 (313) 343-3877 **Approved** for: 8 hours of Category I Credit.

Date: April 10, 1985, Primary Care Medicine: An Exciting Frontier Revisited. Location: Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313) 876-3073. **Approved for:** 6.25 hours of Category I Credit.

Date: April 18-20, 1985, 14th Annual Wayne State University Critical Care Symposium. Location: Northfield Hilton, Troy. **Sponsors:** Wayne State University, Department of Surgery, Michigan Committee on Trauma, and Michigan Society of Critical Care Medicine. **Contact:** Theresa Sokol, Wayne State University, Department of Surgery, 6-C UHC, 4201 St. Antoine, Detroit 48201 (313) 557-5009. **Approved for:** 15 hours of Category I Credit.

Date: May 6-8, 1985, Hemodynamic Monitoring VIII. Location: Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School. **Contact:** Office of Continuing Medical Education, Towsley Center, Box 057, University of Michigan, Ann Arbor 48109 (313) 763-1400. **Approved for:** 14.5 hours of Category I Credit.

Date: May 8, 1985, Pancreatitis. Location: St. John Hospital. **Sponsor:** CME Committee of St. John Hospital. **For:** Interested physicians. **Cost:** $90.00. Contact: Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road, Detroit 48236 (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: May 9-10, 1985, A Team Approach to Aspiration Biopsy & Workshop on Aspiration Biopsy Cytology. Location: Henry Ford Hospital. **Sponsor:** Henry Ford Hospital. **Contact:** Henry Ford Hospital, Continuing Medical Education, 2799 W. Grand Blvd., Detroit 48202 (313) 876-3073. **Approved for:** 12 hours of Category I Credit.

Date: June 12, 1985, 1985 Geriatrics-Family Practice Update. Sponsor: CME Committee of St. John Hospital. **For:** Interested physicians. **Cost:** $90.00. **Contact:** Judy Danbert, Program Coordinator, St. John Hospital, 22101 Moross Road, Detroit 48236 (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: 35th Annual Keyport-Gaylord Trauma Symposium. Location: Hidden Valley Resort. **Sponsors:** Wayne State University, Department of Surgery, Michigan Committee on Trauma. **Contact:** Theresa Sokol, Wayne State University, Department of Surgery, 6-C UHC, 4201 St. Antoine, Detroit 48201. **Approved for:** 15 hours of Category I Credit.

LAW AND EMERGENCY MEDICINE

Rights of the Arrested Patient
Legal Issues of Death
Violence in the Emergency Department

February 4-6, 1985
Boyne Highlands Inn
Harbor Springs, Michigan

For information contact: Michigan Chapter, American College of Emergency Physicians, 1305 Abbott Road, Suite 104, East Lansing, Michigan 48823. Phone: (517) 332-6500.

PRACTICES FOR SALE

GENERAL PRACTICE — Allen Park area. Fantastic location. Shows a nice profit and has rental income. Perfect satellite office.

GENERAL PRACTICE — Howell area. The "only" practice in lovely downtown Howell. Easy access to large office. **Very attractive terms!**

FAMILY PRACTICE — Prescott area. Well-established practice of 40 years. All equipment, records and furniture will remain. Can net **$100,000** to start. Bldg. and land included. Beautiful area for hunting and fishing.

GENERAL PRACTICE — Westland area. Well-established with plenty of modern equipment. Building and land included. NET EARNINGS $100,000 & UP.

MEDICAL PRACTICE — Lansing area. Industrial and family facility. Equipment in good condition. Also, building is optional.

Professional Practice Sales, Inc.
27208 Southfield Road
Lathrup Village, Michigan 48076
HERBERT SILVERMAN, BROKER
(313) 569-7336

Order these free brochures for your breast cancer patients

Breast Cancer Treatments:

A Helpful Guide For *You*

From discovering a lump to recovering from surgery or other treatment — a new MSMS brochure details the steps taken when breast cancer is diagnosed. "Breast Cancer Treatments: A Helpful Guide for You" is a pamphlet designed to answer many of the questions and allay some of the fears your patients will have.

Unlimited quantities are available to you at no charge by writing Joyce Crum, Michigan State Medical Society, 120 W. Saginaw, East Lansing 48823.

Thank you
for the friendship
and good will
you have shown us
throughout
the past year.

◆

May your
Holidays be happy
and your
New Year be
prosperous.

Michigan Physicians
Mutual Liability Company

The rate for each classified advertisement in *Michigan Medicine* is 40¢ per word, with a minimum charge of $20.00. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

POSITIONS OPEN

ASSOCIATE MEDICAL DIRECTORSHIP for one of Ohio's strongest and fastest growing HMOs. This individual will have primary administrative responsibility and some clinical responsibility for a new facility to be operational in mid-1985. For confidential consideration please write Box 72, Michigan Medicine, 120 W. Saginaw, East Lansing 48823.

WANTED: PRIMARY CARE PHYSICIAN and/or P.A. St. Clair, Mi. Open terms. (313) 329-3555 days or (313) 329-2020 or (313) 982-5165 evenings and weekends.

FAMILY PRACTITIONER: LAKE ERIE VACATIONLAND community with 3,000 year around residents seeks Family Practitioner to open new practice. Search effort is supported by nearby 113 bed JCAH Accredited non-profit community hospital with drawing area of 19,000. Hospital affords practitioner Medical/Surgical, ICCU, Obstetrics and Pediatrics Care Facilities along with complete ancillary support including 24 hr. Emergency Room coverage. Pathology, Radiology, Physicial Therapy and Respiratory Therapy. Interested Physicians should contact: Robert Dumminger, Administrator, Magruder Hospital, Port Clinton, Ohio 43452. Phone: (419) 734-3131.

FAMILY PRACTICE: OCONTO FALLS, WISCONSIN. Thirty miles Northwest of Green Bay. Established practitioner needs associate to share fully-equipped clinic adjacent to 50-bed hospital. Income guaranteed by hospital. No ER call required. Abundant hunting, fishing, and recreational opportunities. Contact: Brett Wilson, DO, 835 South Main Street, Oconto Falls, Wisconsin 54154 or call (414) 846-2287.

WANTED: AUDIOLOGIST, CERTIFIED, needed to join in a busy private ENT practice. Competitive salary based upon previous experience. Would desire full training in all diagnostic audiology services including hearing aid fitting and evaluation and ENG training. Please send resume to Raymond R. Komray, MD, 1365 Mercy Drive, Muskegon 49444.

MICHIGAN: EMERGENCY CONSULTANTS, INC. currently staffs Emergency Departments throughout the state. Full-time and part-time positions available in rural and urban locations. Guaranteed hourly rate plus malpractice insurance. Contact Emergency Consultants, Inc., 2240 South Airport Rd., Suite 101, Traverse City 49684; 1-800-253-1795, or in Michigan 1-800-632-3496.

LOCUM TENENS POSITIONS: Well established group has openings in Texas, Ohio, Illinois, Michigan, Wisconsin, Indiana, New York, Virginia, West Virginia and Pennsylvania emergency departments. Independent contractor status with competitive compensation and paid malpractice insurance. Forward CV with availability date and geographic preference to Emergency Consultants, Inc., 2240 South Airport Rd., Suite 101, Traverse City 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

CHAIRMAN - MENTAL HEALTH DEPARTMENT. Assume leadership of growing department with over thirty skilled professionals in Adult Psychiatry, Child Psychiatry, Chemical Dependency Counseling, Psychologists, Social Workers, and Masters Level Nurse Practitioners. Direct further expansion of established, financially stable organization providing a full range of mental health services including individual therapy, pharacotherapy, family therapy, group therapy, conjoint therapy, biofeedback and chemical dependency counselling to 200,000 people in one of America's leading metropolitan areas. Must be oriented toward short term therapy wih proven experience in management. Challenging position for innovative, progressive individual in association with a leader in prepaid health care for twenty-seven years. Direct curriculum vitae to: Paul Brat, MD, Medical Director, Group Health, Inc., 2829 University Avenue Southeast, Minneapolis, Minnesota 55414. An equal opportunity employer

READY FOR A CHANGE OF PACE? The Air Force has openings for physician specialists. You can enjoy regular working hours, 30 days of vacation with pay each year, worldwide travel opportunities and a unique and enjoyable lifestyle for you and your family, while serving your country. Ask a health professions recruiter about our outstanding pay and benefits package. Call collect: (313) 561-7018.

OPHTHALMOLOGIST, BOARD CERTIFIED OR ELIGIBLE, to join active surgical/medical practice in suburb of Detroit. Full-time. Excellent opportunity. Reply with CV to Box 70, Michigan Medicine, 120 W. Saginaw, East Lansing 48823.

HENRY FORD HOSPITAL FAIRLANE CENTER is seeking physicians in General Internal Medicine, Obstetrics & Gynecology, Emergency Medicine, Dermatology, Pediatrics, Orthopaedics, Family Practice and other specialties. Send CV to Michael E. Somand, MD, Medical Director, Henry Ford Hospital Fairlane Center,19401 Hubbard Drive, Dearborn 48126.

LOCUM TENENS POSITION AVAILABLE for Family Practitioner for the months of January through May 1985 at CIGNA Healthplan, an established, growing, progressive prepaid group practice in Phoenix, AZ. An opportunity to practice in a desirable environment coupled with a leisurely southwestern lifestyle. Please submit CV to: Director, Physician Recruitment, CIGNA Healthplan, P.O. Box 44678, Dept. LTM, Phoenix, AZ 85064, (602) 954-3506. EOE

GENERAL SURGERY RESIDENCY PROGRAM DIRECTOR needed by 210 physician multispecialty private group practice in central Wisconsin. Board certified general surgeon with subspecialty training and interest in peripheral vascular surgery plus strong academic interests are being considered. This surgeon would join a seven member General Surgery Section with subspecialty expertise and experience. A clinical appointment through the University of Wisconsin Medical School is available as are research opportunities. Please call Gail H. Williams, MD, Surgery Department Chairman, or Sidney E. Johnson, MD, Medical Director collect at (715) 387-5609 and (715) 387-5253 respectively or send curriculum vitae to: Gail H. Williams, MD, Chairman, Department of Surgery, Marshfield Clinic, Marshfield, WI 54449.

PSYCHIATRIST, PART-TIME, TO DO OUTPATIENT psychotherapy in private clinic in Adrian, Michigan, to do evaluations and psychotherapy; not to sign insurance forms or to prescribe medications. An excellent opportunity to work with experienced professionals (PhD, psychologists and MSWs) in pleasant and expanding private practice setting. Adrian, Michigan is located 35 miles southwest of Ann Arbor. Send resume to: Brenda Meisels, ACSW, 3449 Brassow Rd., Saline 48176, or call (313) 429-2463.

CARDIOLOGIST: OPPORTUNITY TO PRACTICE cardiology with well-established practice conveniently located to a large teaching hospital. Duties include supervising and interpreting Treadmills, Holter monitors, 2D and M-Mode Echocardiography performed in office, patient examinations, hospital rounds and cardiac catheterizations. Abilities to do streptokinase and/or angioplasty desirable. Excellent beginning salary and fringe benefits. Located in Pennsylvania. Reply with CV to Box 66, Michigan Medicine, 120 W. Saginaw, East Lansing 48823. Immediate Opening.

FAMILY PRACTICE. GREATER FLINT HMO, a non profit subsidiary of Blue Cross-Blue Shield of Michigan, has several excellent opportunities for Board eligible Family physicians. The staff model HMO is two years old and growing rapidly. It offers the chance for physicians to practice true Family medicine in two beautiful facilities. Competitive salaries and a very attractive fringe benefit package are offered. Interested physicians should contact Doctor William Griz at (313) 733-9500.

MEDICAL DIRECTOR. OPPORTUNITY FOR PHYSICIAN with experience in medical group practice administration to join established HMO in Madison, Wisconsin. Group Health serves 29,000 patients with its staff of 20 physicians and total staff of 180. Excellent salary and benefit program. This represents a rewarding opportunity to develop or progress your career in medical administration. Contact: John Mueller, Group Health Cooperative, 1 South Park St, Madison, WI 53715; (608) 251-4156.

FAMILY PRACTICE. RAPIDLY EXPANDING STAFF MODEL HMO in Madison, Wisconsin, has opportunities for additional family practice physicians. Competitive salary with excellent benefits and attractive practice setting. GHC is an established, rapidly growing HMO serving 29,000 patients. Current staff totals 180 employees, including 20 physicians. Contact: John Mueller, Group Health Cooperative, 1 South Park St, Madison, WI 53715; (608) 251-4156.

OB/GYN. GROUP HEALTH COOPERATIVE has 1984 opening for Board certified/eligible obstetrician and gynecologist. GHC is an established, rapidly expanding HMO. Staff enjoy a stable salary plus excellent benefit program including 5-6 weeks of time off plus $3,000 CME funding. Madison is a city of 200,000 population; University of Wisconsin; and 4 lakes. Contact: John Mueller, Group Health Cooperative, 1 South Park St, Madison, WI 53715; (608) 251-4156.

FAMILY PRACTIONERS, GENERAL PRACTIONERS or Emergency Medicine Physicians-with practice experience wanted for free-standing urgent care centers located in the Central Michigan area. Excellent access to recreational areas. Associate and Medical Director opening immediately. Other vacancies opening in August or September of 1984. Salary negotiable plus fringe benefits. Send C.V. to Contemporary Medical Management, Incorporated, 401 South Euclid Avenue, Bay City 48706 (517) 667-0494.

GENERAL SURGEON, OB/GYN AND INTERNAL MEDICINE SPECIALISTS to join seven doctor Family Practice Clinic in Cloquet, Minnesota, a community of 12,000 (30,000 service area) located 20 minutes from Duluth-Superior. Clinic facility is located one block from modern, well equipped 77 bed hospital. Cloquet enjoys a stable economy (forest products). Additionally, our community is noted for its excellent school system. First year salary guarantee, paid malpractice, health and disability insurance, vacation and study time. Contact John Turonie, Administrator, Raiter Clinic, Ltd., 417 Skyline Blvd., Cloquet, MN 55720. Telephone (218) 879-1271.

POSITIONS WITH THE STATE OF MICHIGAN—Currently taking applications for positions expected to be available in the future. Office locations now include Kalamazoo, Lansing, Southfield, and Traverse City. A board certified or board eligible psychiatrist needed for the Kalamazoo office, and internists desired for other offices. Beginning salary in low 60's with approximately 26% fringe benefits. An equal opportunity employer. All inquiries treated confidentially. For further details, please write: Chief Medical Consultant, Disability Determination Service, PO Box 30011 Lansing, 48909.

FAMILY PHYSICIAN: IMMEDIATE OPENING for a residency trained FP preferring small-town life style and interested in "whole person medicine from the Christian perspective" in a new office in the small college town of Hillsdale in southern Michigan. Write or call: Frederick L. Bean, MD, Hillsdale Family Practice, 111 South Howell, Hillsdale, 49242.

POSITIONS WANTED

OPHTHALMOLOGIST AVAILABLE for locum tenens. Board certified. Also interested in full time or part time position. Contact Box 39, Michigan Medicine, 120 W. Saginaw, East Lansing 48823.

ANESTHESIOLOGIST AVAILABLE FOR LOCUM TENENS. Board eligible, U.S. medical school grad, licensed in Michigan and Indiana. Available full time. Contact Box 73, Michigan Medicine, 120 W. Saginaw, East Lansing 48823.

MISCELLANEOUS

FOR LEASE: TRAIL CLINIC IS PLANNING an all new medical professional plaza located at 7531 E. Eight Mile at Van Dyke in Warren, Michigan. The facility will be situated adjacent to the Trail Clinic Building on two acres of land with over 500 feet of frontage facing Eight Mile. The building is a two story design and measures approximately 30,000 square feet, sky lit roof, elevator, ample lighted parking and a dramatic front and rear entrance are just a few features that give the facility a most attractive appearance. The city of Warren is the third largest city in the state of Michigan with the total population for Warren and the surrounding community totaling 1/2 million. Fifteen suites are available for lease. We offer attractive incentives for early commitments. For further details or appointments call or write: Atlantis Properties, c/o Rhonda Ramsey, 10163 Gratiot, Detroit 48213; (313) 921-8080.

PRACTICE FOR SALE. Excellent Internal Medicine practice. High growth Lake Michigan community. Ideal location. Good equipment and office. Call Mr. Leon Kruithof (616) 456-1781.

FOR LEASE: FOUR BLOCKS FROM GROSSE POINTE fully equipped medical suite available December 1984. Five treatment rooms, business office, large panelled private office, x-ray unit with processor four years old. Other tenants include a complete diagnostic service with fluoroscopy, nuclear medicine, ultrasound and stress testing with a full-time radiologist. Close to St. John & Bon Secours. Call Rhonda Ramsey (313) 921-8080.

KALAMAZOO, MICHIGAN. LUXURIOUS FIVE YEAR old home with in-home medical office. Offers family privacy with convenience. Great for solo practioner or female Doctor with young children. Located in an active commercial-residential area. For full information call evenings (616) 385-1851.

BURDICK CARDIOESCONT - almost new $1,200.00. Call (313) 429-5426 weekdays.

GENERAL OPHTHALMOLOGY PRACTICE FOR SALE; established, busy in stable suburb of Detroit. Surgery, medical, contacts, referrals. Excellent opportunity. Respond to Box 70, Michigan Medicine, 120 W. Saginaw, East Lansing, 48823.

PHYSICIAN OPPORTUNITIES. Bernie Hoffman Associates, Inc. is currentlyassisting a major metropolitan Detroit Health care provider in the expansion of their suburban clinic network. The search for qulified physicians includes the following specialties: Obstetrics and Gynecology, Emergency Medicine, Family Practice, Internal Medicine, Orthopedic Surgery and Pediatrics. The typical statellite center provides an excellent practice setting for a four person physician group. There are over 30 opportunities for board eligible or board certified physicians with available starting dates of 10/1/84, 1/1/85, and 7/1/85. A compensation program emphasizing flexibility and incentive will be explored with invited candidates. Interested physicians should submit curriculum vitae in confidence to: Tim Ignash, Senior Associate, Bernie Hoffmann Associates, Inc., One Northland Plaza, 20755 Greenfield, Suite 601, Southfield 48075 (313) 557-9340.

HOLTER MONITOR SCAN SERVICE — Scanning for cartridge, cassette or reel-to-reel recorders by a company in the medical field for over twenty years. QUALITY REPORTS PRODUCED BY QUALIFIED TECHNICIANS AND CARDIOLOGISTS. Reports returned in 24 hours. Recorders and hook-up kits available. For further information call Advance Medical and Research Center 1-800-552-6753.

SANIBEL ISLAND, FLORIDA LIGHTHOUSE POINT condominium completely furnished for sale by owner. Never rented. Pristine condition. 3 bedroom magnificent bay view. Beach. $198,500.00. Assume 9% mortgage. (813) 472-3719 or (317) 251-0321.

1985 CME CRUISE/CONFERENCES ON SELECTED MEDICAL TOPICS — Caribbean, Mexican, Hawaiian, Alaskan, Mediterranean. 7-14 days year-round. Approved for 20 — 24 CME Category 1 credits (AMA/PRA) & AAFP prescribed credit. Distinguished professors. FLY ROUNTRIP FREE ON CARIBBEAN, MEXICAN, & ALASKAN CRUISES. Excellent group fares on finest ships. Registration limited. Pre-scheduled in compliance with present IRS requirements. Information: International Conferences. 189 Lodge Ave., Huntington Station, NY 11746. (516) 549-0869.

WHY PAY PER SCAN? Lease brand new ACR Holter Recorder for under $70.00 per month! Medical Leasing Company, (313) 879-8860.

FOR SALE. MARCO ISLAND CONDOMINIUM, high-rise, on the beach. Beautiful Gulf of Mexico view and island view. Two bedroom - two and one-half baths-approximately 2000 square feet. All amenities. For the discriminating buyer. Decorator furnished. Call area (313) 651-3071.

DOCTOR, YOU CAN'T BEAT THE QUALITY OR THE PRICE! Holter Monitor scanning service. Physician owned, trained and supervised. $35.00 for cassette reports: $45.00 for reel to reel reports; No contracts to sign. We can arrange for lease/purchase of holter equipment. Why are you paying more and getting less? DCG Interpretation (313) 879-8860.

50% OFF PREVIOUSLY OWNED MEDICAL, laboratory office, x-ray and ultra-sound equipment in excellent condition. We buy, sell, broker, and repair. Office appraisal available by Certified Surgical Consultants. Call Doctor Medical Resale Ltd (313) 569-4407, 9 am-9 pm.

PHYSICIAN SIGNATURE LOANS TO $50,000. Up to 7 years to repay. No prepayment penalties. Prompt, courteous service. Competitive fixed rate, with no points, fees or charges of any kind. Physicians Service Association, Atlanta, GA. Toll-free (800) 241-6905.

Thanks to our avertisers

Advance Medical and Research	681
American Physicians Life	685
Ayerst	636, 638, 656-58, 671-78, 695-698, 708-710
Bennethum Computer Systems, Inc.	706
Brown Pharmaceutical	683
GTE Telenet	647
Henry Ford Hospital	663
Institute for Health Maintenance	667
Knoll	652-54
Laboratory for Clinical Medicine	693
Eli Lilly	689
Marion Labs	699-700
MDPAC	703
Medical Protective	707
Michigan ACEP	628
Michigan Conference on Maternal and Perinatal Health	693
Michigan Physicians Mutual Liability Co.	713
PICOM	691
Professional Practice Sales	712
Roche	IBC - BC
Rollins Medical/Dental Systems	665
Source Systems, Inc.	669
Stratton-Cheeseman	Front Insert
Upjohn	649-650
Woodside Capital Corp.	666

Happy Holidays!

SANTA IS FEEDING HIS REINDEER
JOHNS

"He keeps them in the men's room."

Is it *really* worth it?

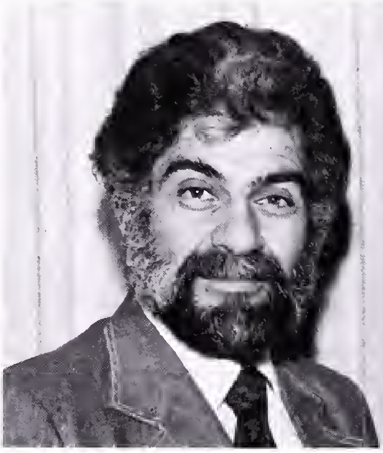
The majority of you reading this page are members of the Michigan State Medical Society and a county medical society. Of 11,000 MSMS members, approximately three-fourths also are members of the American Medical Association. Further, one-third make additional voluntary contributions to Michigan Doctors Political Action Committee (MDPAC) and American Political Action Committee (AMPAC).

Current MSMS dues for active membership are $290, while component society dues range from less than $50 for some rural counties to a high of $220 for Wayne County. AMA dues are an additional $330. For Wayne County physicians this totals $840. Add $50 for MDPAC/AMPAC or $150 for sustaining PAC membership and we are talking about almost $1,000, albeit tax-deductible, spent on medical society dues and fees. Is it *really* worth it?

Frankly, that's one heck of a lot of money for a few journals and a variety of often nebulous member benefits. The logical questions then, are why join and are there any reasonable alternatives? A lot of physicians *not* reading this page have at one time or other asked themselves similar questions and have decided to save money by not joining the AMA, or even *more* money by not joining MSMS and their county society. You and I continue to pay our dues out of habit and loyalty, both of which are tested as dues continue to rise.

Alternatives

What are the alternatives? Three seem feasible to me. The first is to remain a loyalist and take comfort in the tax-deductible nature of the contribution. The second is to drop our membership and save $500-$600 in after-tax income. The third is to become aware of what the freeloaders within the medical profession are doing to the rest of us and to begin to make life uncomfortable for them.


Louis R. Zako, MD
MSMS President

If the physicians nationwide who are neither AMA nor MSMS members were to join, the impact on dues, and perhaps more importantly, on organizational effectiveness would be phenomenal.

Is this likely to happen in the foreseeable future? Not likely, inasmuch as compulsory membership, thank God, is not in the cards. Can we improve over the present level of membership through eyeball-to-eyeball discussion with non-member colleagues and some gentle arm twisting? Without a doubt, yes!

Are the leaders of organized medicine, where membership is purely voluntary, out of touch? I think not, although one might point out that I am not in an entirely objective position. But it seems to me that the John Courys, the Joe Boyles, the Tom Berglunds, the Dick McMurrays, and the Lou Zakos of organized medicine are very much in touch with the concerns and values of MSMS members *and* non-members.

No physician could feel more strongly than I feel about the gross injustice of the current state of medical malpractice, a system in which no one wins. No one of you could be more concerned than AMA President Joe Boyle about the very real prospect of arbitrary health care rationing in light of the political hysteria over health care costs. No one of you could be more concerned over the threat to the financial stability of a young physician starting practice with a debt of $50,000-$100,000 than MSMS Board vice-chairman Carl Gagliardi.

Effective?

I honestly believe that we are very *much* in touch with your concerns. However, are we effective enough to warrant your paying several hundred dollars in dues each year?

My own answer is that the AMA, MSMS, AMPAC, MDPAC are much more effective than most of us realize and less effective than we might be. Our effectiveness is limited both by medicine's leaders' individual and collective shortcomings and by the limitations imposed by unacceptably low membership figures.

Frankly, we need the money and the political clout of representing the vast majority of physicians, not just half or three-fourths. Without AMA, MSMS, our county societies, who speaks for us at the national, state, and local levels? Who speaks for patients, the poor, the old, the critically ill, when legislators, labor leaders and business executives shrilly decry the escalation of health care costs for which they are in no small measure responsible?

Help us to do a better job. Let's prick the conscience of the freeloader. Let's work together for the public good and for our continuing professional independence.□

COMPLETE LABORATORY DOCUMENTATION[1-5]... EXTENSIVE CLINICAL PROOF

FOR THE PREDICTABILITY CONFIRMED BY EXPERIENCE

DALMANE® Ⓒ
flurazepam HCl/Roche

THE COMPLETE HYPNOTIC PROVIDES ALL THESE BENEFITS:

- Rapid sleep onset[1-6]
- More total sleep time[1-6]
- Undiminished efficacy for at least 28 consecutive nights[2-4]
- Patients usually awake rested and refreshed[7-9]
- Avoids causing early awakenings or rebound insomnia after discontinuation of therapy[2,5,10-12]

Caution patients about driving, operating hazardous machinery or drinking alcohol during therapy. Limit dose to 15 mg in elderly or debilitated patients. Contraindicated during pregnancy.

DALMANE® Ⓒ
flurazepam HCl/Roche

References: 1. Kales J *et al*: *Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A *et al*: *Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A *et al*: *Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A *et al*: *Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol 3*:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **9.** Amrein R *et al*: *Drugs Exp Clin Res* 9(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol 3*:303-326, May 1981. **11.** Greenblatt DJ *et al*: *Sleep 5*(Suppl 1):S18-S27, 1982. **12.** Kales A *et al*: *Pharmacology 26*:121-137, 1983.

DALMANE® Ⓒ
flurazepam HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE
Roche Products Inc.
Manati, Puerto Rico 00701

DOCUMENTED IN THE SLEEP LABORATORY[1-5]...
PROVEN IN THE PATIENT'S HOME
FOR A COMPLETE NIGHT'S SLEEP
DALMANE® ⓘⓥ
flurazepam HCl/Roche
STANDS APART
15-MG/30-MG CAPSULES

See preceding page for references and summary of product information.
Copyright © 1984 by Roche Products Inc. All rights reserved.